

Mental health, resilience and the recession in Bradford

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How personal coping strategies and financial support help to moderate the impact of unemployment at a time of economic recession in Bradford.

This study explores the impact of involuntary unemployment at a time of economic recession on people's everyday life and mental well-being. It explores the relation between people's experiences of unemployment and two sets of resilience factors: coping strategies and practical and emotional support.

The study consisted of 16 focus groups with 73 unemployed people in a 'transition phase' in the job market: young people (aged 18–25) who recently entered the job market and older workers (aged 50–65) closer to retirement age.

The report covers the following questions:

- What has been the impact of job losses on people's everyday lives and well-being?
- What have been the experiences and views of help and support from family, friends and formal services?
- What practice and policy recommendations are there to promote mental well-being and resilience during economic downturns?

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This study set out to explore the impact of involuntary unemployment at a time of economic downturn on people's everyday life and mental well-being. It investigated whether there were gender and age differences in people's experiences of unemployment and the role of personal, social and local resources for their resilience. The study focused on unemployed people in a 'transition phase' in the job market – young people (aged 18–25) who had recently entered the job market, and older workers (aged 50 and over) who were closer to retirement age. Research has shown that these groups are particularly at risk of being hit hard by the economic recession and so are at higher risk of reduced mental well-being and of mental health problems.

Findings from existing research

There is strong evidence in the literature that unemployment is negatively associated with mental health and well-being (defined as life satisfaction). However, the causal link between unemployment and mental health can go in two ways: mental health problems can cause unemployment and unemployment can cause mental health problems. Unemployment also has a major and lasting effect on people's satisfaction with their lives. It is one of the few life events (another is widowhood) that can change people's 'life satisfaction set-point', that is, the baseline level of satisfaction with life to which people tend to return after experiencing a crisis. Research has shown that unemployed people do not return to their original life satisfaction baseline even many years after they regained employment.

The literature on unemployment and mental health consists of individual-level studies, which investigate the experiences of unemployed people, and ecological studies, which investigate how the population health changes at times of economic downturn.

Individual-level studies have consistently shown that unemployment is negatively associated with the mental health and well-being of those living 'on the dole'. This literature has suggested a plurality of mechanisms through which unemployment might cause mental health problems and reduced well-being. However, there is scant empirical research that investigates and empirically tests any of these. The literature has also investigated what factors moderate the impact of unemployment on people's mental health and well-being. These factors have been categorised in different ways; mostly all categorisations include some or all of the following elements: coping strategies, social support, cognitive appraisal of the situation, financial resources, work role centrality and personal characteristics (for example, age and gender).

Ecological studies show that at times of economic recession there are higher suicide rates in the population. However, all-cause mortality rates, that is, death due to any and all causes, and certain specific mortality rates, for example, mortality by car accidents, rise during phases of rapid economic expansion and slow down during phases of economic recession. The literature consistently reports that the positive associations between rising rates of unemployment and suicide rates, and between economic expansion and all-cause mortality rates, are stronger in countries with weak social welfare systems than in countries with stronger welfare systems. It suggests that governments can have a fundamental role in buffering the negative impact of economic downturns on suicide rates and people's mental health by adopting policies aimed at keeping and reintegrating people at work.

Although there is a wide body of research on the impact of unemployment on people's mental health and well-being, only a few studies have investigated interventions that can help to improve them. Interventions aimed at improving unemployed people's mental health and well-being have been based in three different settings: primary care, labour market programmes and the community.

Interventions in primary healthcare have consisted either of information programmes for general practitioners (GPs) or of 'social prescribing'. Social prescribing promotes the use of the voluntary sector within primary healthcare. It involves signposting primary healthcare patients with non-clinical needs to local voluntary services. There is growing evidence of the efficacy and cost-effectiveness of this approach. Interventions in labour market programmes entailed primarily cognitive behaviour therapy (CBT) support for unemployed people. Research has shown that CBT improves mental well-being among people with a history of mental health problems, but not necessarily in the unemployed population at large. Examples of community-based initiatives that could serve as settings for interventions for unemployed people are the Work Clubs recently started by the Department for Work and Pensions (DWP) and the Community Health Champions programme.

Findings from the qualitative study

This study confirmed many of the findings in previous research on the negative impact of unemployment on people's mental health and well-being. In particular, it contributed to the investigation of how gender and age moderate the impact of unemployment on people's mental well-being. The study participants talked extensively of six experiences associated with being unemployed during the economic recession that negatively affected their mental well-being:

- financial strain caused by income loss;
- difficulty in finding a job due to the stronger market competition;
- loss of time structure in the day;
- loss of social role;
- anger and frustration for one's situation;
- stigma attached to being unemployed.

Financial strain and job market competition were two manifest consequences of, respectively, job loss and job loss at a time of economic recession. The remaining four experiences consisted of the emotional and psycho-social consequences of both involuntary job loss and the acquired status of becoming unemployed.

Two sets of resilience characteristics affected people's capacity to manage the effects of those experiences and to address some of the factors leading to them: their personal resources and coping strategies, and the practical help and emotional support that they received from their family and friends.

Some study participants engaged in problem-focused coping strategies that were aimed at re-entering work. All of the study participants engaged in emotion-focused coping strategies. Women were more open to sharing their distress with relevant others and thus to find relief from it, whereas men were more likely to engage in avoidance strategies. However, while younger male participants often talked of abusing alcohol and taking illegal drugs to cope with their stress, older male participants did not refer to these types of coping strategies. Instead they engaged with downward social comparison, a self-enhancement strategy that consists of comparing oneself to people who are in a worse situation.

Many study participants reported that unemployment had a major financial impact on them. This was often described as entailing, in practical terms, the inability to afford running their car, paying the rent, paying bills and, in some cases, buying fresh food. Families were often the primary source of practical and financial help for those who had one or were in contact with them. Some study participants found their

families a fundamental source of both practical and emotional support; others received material support, but not emotional support. Not all study participants considered family members the best people to turn to for sharing their stress and depression symptoms. Several participants preferred to talk about their problems with someone outside their usual family and social networks.

The study participants talked extensively of their experiences with a variety of services: the job centre, their personal doctor and several other services, from utility companies and banks to volunteering.

Participants had contrasting views on the services they received from the job centre. Several were frustrated from having to wait six months before being able to receive full support to look for a job. Among those who were enrolled in retraining courses, some found them useful, others demotivating and a waste of time. The main reason for this was that all unemployed people were offered the same kind of courses regardless of their previous experiences and education.

Many study participants were reluctant to go to their GP to address their symptoms of depression and stress. The main reason was that they did not want to be prescribed antidepressant tablets, which were seen as a source of stigma. One study participant was offered CBT to address her depressive symptoms, but was informed that there was a waiting list of ten months.

Several participants suggested that those who cannot afford to keep up with the payment of their utility bills should be given a chance to stop and postpone their payments for a while.

The stakeholders interviewed as part of the study mentioned five main concerns regarding the recession; in particular that it could:

- generate more social and health inequalities;
- have a negative impact on the possibilities of people with a history of mental health problems to re-enter the job market;
- raise the rate of lifestyle risk factors such as alcohol consumption and smoking;
- fully show its impact on the demand of mental health services even after the start of economic recovery;
- cause reduced public funding.

The latter point was particularly stressed by voluntary sector stakeholders, who unanimously reported that the demand for their services had risen in the last years, placing a strain on their resources.

Conclusions

This study confirms the findings of previous research on the ways in which unemployment can negatively affect people's mental health and well-being. It highlights the need to help unemployed people to increase their coping strategies and to mitigate the financial impact of income loss and debt on their everyday life. It also indicates the need to raise awareness regarding the stigma that the study participants felt was associated with unemployment and living in particular housing estates in Bradford. Stigma in relation to mental illness was also one of the main causes of the study participants' reluctance to turn to their GPs to ask for help with regard to their stress and depression symptoms.

This study has highlighted five main issues that require further policy attention:

- the need to address the financial burden of debt on people's everyday life;
- the need to facilitate emotional support for unemployed people (including stigma), particularly for unemployed men;
- the need to improve people's ability to keep a structure and a routine to the day;
- the need to address the 'unhealthy' coping strategies adopted by some young unemployed men;
- the need to raise public awareness of the impacts of unemployment and hence attempting to reduce the stigma associated with both unemployment and mental ill health.

The literature on the relation between macro-economic changes and population health shows that governments can have a crucial role in buffering the effects of unemployment on suicide and on unemployed people's mental health by adopting policies that maintain and reintegrate people into work.

At the local level, the following interventions could also help to address the above issues:

- further expanding public interventions aimed at reducing the burden of debt on people's everyday life;
- developing Work Clubs, a recent DWP initiative which 'aims to support the development of a network of locally led, community based support for the unemployed which will grow organically across the country' (DWP, 2010);
- expanding the social prescribing service that is currently only available in one of the four practice-based commissioning alliances in Bradford (that is, Bradford South and West Practice-based Commissioning Alliance);
- reducing the long waiting lists for CBT;
- strengthening cross-sector collaborations aimed at early diagnosis and early interventions for people who develop mental health problems while unemployed;
- strengthening existing services aimed at helping people with a history of mental health problems to re-enter work;
- ensuring geographical spread of services and initiatives aimed at promoting mental health, well-being and resilience.

Despite the reduced funding that the public sector will be facing in the coming years, the above-suggested interventions may require that more resources are invested in the voluntary sector and in non-statutory services, such as libraries, to support and run community-based initiatives in Bradford (and elsewhere). Voluntary sector and some non-statutory services might be of fundamental importance to develop strategies that help strengthen people's resilience at times of economic recession.

1 Introduction

Background to the study

This study was commissioned by the Joseph Rowntree Foundation (JRF) to explore the effects of the economic downturn on mental health and well-being in Bradford. It was funded under the Living Through Change programme, which aims to identify possible policies and strategies that might help Bradford to address the longer-term implications of the global economic downturn.

Two main consequences of economic recessions are rising unemployment rates and increased job insecurity. Research has consistently shown that both these life events are associated with a higher prevalence of mental health problems and/or diminished well-being. Both mental health and well-being are influenced by a number of factors at the structural level (for example, employment levels, education, public policies), at the community level (for example, social support and participation in society) and at the level of the individual (for example, psychological and demographic characteristics). There is a growing body of research that focuses on the investigation of protective factors that moderate or 'buffer' risk factors and therefore reduce their impact on mental health and well-being. Such factors confer characteristics of 'resilience', that is, the capability to cope successfully in the face of significant adversity or risk, to individuals, families, groups and communities (Stewart *et al.*, 1999). At the individual level, resilience has been associated with active coping strategies, which involve adopting a problem-solving approach to a stressful situation (Kirkwood *et al.*, 2008). At the community level, resilience can provide some protection from the effects of deprivation and has been associated with norms of trust, tolerance, support, participation and reciprocity (Friedli, 2009).

Study aims and objectives

The study aimed to investigate the impact of involuntary unemployment at a time of economic downturn on people's everyday life (their plans, sources of help and lifestyle) and mental well-being (their ability to cope, their morale and their sense of connection with others). Its objectives were to:

- explore the role of personal, social and local resources in determining people's experiences of unemployment at a time of economic recession;
- explore whether there were gender and age differences in unemployed people's experiences of mental well-being and their views regarding access to local resources and services;
- identify possible practice and policy recommendations to strengthen and promote mental well-being and resilience among unemployed people at a time of economic recession in Bradford;
- explore whether Bradford presented characteristics of resilience comparatively to similar local authorities.

The study focused on the experiences of unemployed people in a 'transition phase' in the job market – young people (aged 18–25) who had recently entered the job market, and older workers (aged 50 and over) who were closer to retirement age. Research has shown that these groups are particularly at risk of being

hit hard by the economic recession (Vaitilingam, 2009) and so are at higher risk of reduced mental well-being and of mental health problems.

Definition of terms

The term 'mental health' is defined as both absence of mental illness, that is, psychological and psychiatric disorders, and mental well-being, which is defined as 'a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment' (DH, 2010, p. 12). The concept of well-being is multi-faceted. Steel, Schmidt and Schultz (2008) suggest that it encompasses four distinct dimensions: life satisfaction, happiness, affect (positive and negative) and quality of life. Life satisfaction and quality of life entail cognitive evaluations respectively of one's life as a whole and of single life dimensions, for example, social life and personal safety. Happiness and affect refer respectively to a specific and temporary emotional state and to the full spectrum of emotions, from positive, for example, joy, to negative, for example, sadness and anxiety. As will become clearer in the next chapter, macro-economic changes, that is, economic downturns or upturns, affect each of the four dimensions of well-being differently. In this report, the term 'well-being' will be primarily used to refer to the full spectrum of people's emotional experiences and to their quality of life.

'Resilience' is a contested term that has been interpreted in different ways across different disciplines. Batty and Cole (2010) describe it as an agency-centred and dynamic term that refers to some people's ability 'to withstand repeated setbacks' (p. 8). Others have described resilience as some people's capacity to use their difficulties to take positive steps forward in their lives (Burchardt and Huerta, 2008). Norris, Tracy and Galea (2009) suggest that the concept of resilience should be distinguished from that of 'resistance' and that it is better described as some people's capacity to 'bounce back' to the state of mental well-being that preceded a significant stress. It therefore refers to some people's capacity to quickly regain their original level of mental well-being and functioning after these have been worsened because of some major distress. In this study the concept of resilience is used in the latter of the three reviewed meanings. This study explored in particular whether the study participants showed elements of resilience, and what factors helped to achieve resilience.

Methods

The study consisted of two components:

- a literature review on the impact of previous economic recessions on population health and well-being and on interventions intended to build resilience and address the mental health needs of unemployed people;
- a series of 16 focus groups with unemployed people and nine individual interviews with stakeholders of mental health and other support services in Bradford.

With regard to the fourth study objective, the plan was to use the Quality and Outcomes Framework (QOF) datasets to compare the prevalence rates of depression before and after January 2009, when Britain officially entered into recession (The Health and Social Care Information Centre, 2010). However, contrary to the authors' expectations, the data on the prevalence of depression published in the QOF 2009/10 dataset was not comparable to the prevalence data published in the 2008/09 dataset. This was because the former was age-specific whereas the latter was not.¹ So, the prevalence rates of depression in Table 1 can only be compared vertically, that is, across different geographical entities (Bradford and Airedale Primary Care Trust [PCT], Yorkshire and the Humber, and England), but not horizontally, that is, across time. Also, QOF

information is collected at an aggregate level – there is no patient-specific data, which is needed to run more in-depth analyses on the depression prevalence in Bradford comparatively to similar other districts.

Literature review

The literature review followed a purposive review methodology. It did not intend to systematically retrieve all the research produced on the above-mentioned topics, but rather to offer a comprehensive panorama of different perspectives on them (Civil Service, 2009). More details regarding the keywords and databases searched can be found in Appendix I.

Qualitative study

The qualitative investigation consisted of 16 focus group interviews with 73 men and women of mixed ethnic backgrounds who had involuntarily lost their jobs at any point in time from July 2008. This date represents the start of the two quarters of negative economic growth that led Britain to officially enter recession in January 2009, the assumption being that people were made redundant as a consequence of the economic downturn. The study participants were recruited from July 2010 to October 2010 following three main routes: 'opportunistic' recruitment outside the main Jobcentre Plus in Bradford, through managers of local community centres that run employment programmes and through two announcements on a local radio station. This strategy aimed to recruit unemployed people from a variety of work experiences. The study participants were grouped in three main age groups: 18–25, 26–49 and 50 and over (a breakdown by demographic and socio-economic characteristics of the study participants can be found in Appendix II). Those aged 18–25 and 50 and over were the main target of the study, as they represented unemployed people in a 'transition phase' in the job market. Those aged 26–49 represented the comparison group; they were interviewed to check whether there were any specific elements in the experiences of unemployment, help-seeking and support of those in a 'transition phase'. Men and women of each age group were interviewed separately to better investigate how gender affected their views and experiences of job loss, help-seeking and support.

Considering the sensitive nature of some of the topics discussed in the focus groups, the study participants were asked to comment on short stories, called 'vignettes', which were based on fictitious characters who lost their jobs as a consequence of the economic recession. This technique avoided asking the study participants directly about the emotional and everyday life impact of their job loss. It allowed them to contribute to the discussion without feeling pressured to disclose personal experiences unless they chose to do so.

As part of the research project, nine semi-structured individual interviews were undertaken with stakeholders of mental health and other support services in Bradford. Five were from statutory sector organisations and four from voluntary sector organisations. The interviews investigated the stakeholders' points of view regarding the services aimed at promoting mental health and well-being in Bradford and how these could help to support people who lost their jobs as a result of the economic recession. The content of these interviews was used to inform the discussion of the findings from the focus group interviews.

Both the focus group and the individual interviews were audio-recorded with the consent of the study participants and then fully transcribed. The transcripts from the focus group and individual interviews were analysed using a thematic approach (Silverman, 2009). An illustration of the procedure followed to undertake and validate the data analysis is offered in Appendix III.

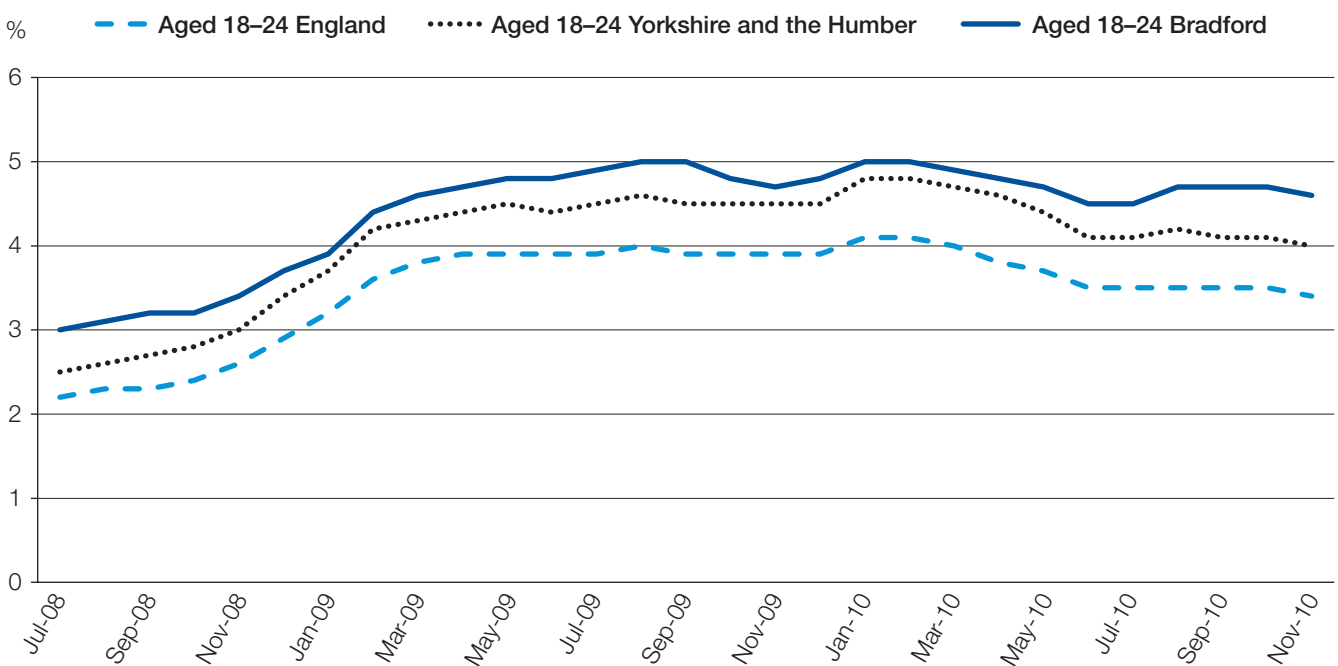
Economic and social context

Bradford shows one of the lowest proportions of working-age residents in employment compared to any other local authority in the Yorkshire and the Humber region and is lower than the national average (Bradford Joint Strategic Needs Assessment, 2009). Likewise, it has one of the highest unemployment rates (Bradford Joint Strategic Needs Assessment, 2009). Throughout the recession period, Bradford maintained a higher Jobseeker's Allowance (JSA) claimant rate compared to both the Yorkshire and the Humber region and England as a whole (see Figure 1). Figures 2, 3 and 4 show that Bradford had a higher JSA claimant rate compared to the Yorkshire and the Humber region and England as a whole across all main age groups. A breakdown of JSA rates in Bradford, Yorkshire and the Humber and England by age groups and length of unemployment is reported in Appendix IV. Nevertheless, young people make up a larger proportion of the district's population than the national average, with relatively high percentages of young people in South Asian communities (Bradford Joint Strategic Needs Assessment, 2009). The adult working-age population is expected to grow by approximately 6 per cent over the next five years (Bradford and Airedale Teaching PCT, 2008).

The percentage of working-age people claiming benefit with a diagnosis of mental or behavioural disorders in Bradford is significantly higher than the national average, 35.4 per cent compared to 27.4 per cent nationally (Bradford and Airedale Teaching PCT, 2008). People from South Asian origin are 42 per cent more likely to have a depressive episode and 14 per cent more likely to suffer from mixed anxiety and depressive episodes than the general population (City of Bradford MDC and NHS Bradford and Airedale, 2008). However, QOF data shows that Bradford presents a lower prevalence rate of depression when compared to the Yorkshire and the Humber and England, both in the period from April 2008 to March 2009 and in the period from April 2009 to March 2010 (see Table 1).

The lower prevalence of depression in Bradford could be due to a variety of factors. Keyes (2007) mentions that 'many people do not seek or accept treatments for mental illness when they believe their condition is a normal response to environmental conditions' (p. 5). The findings of this study expand on this

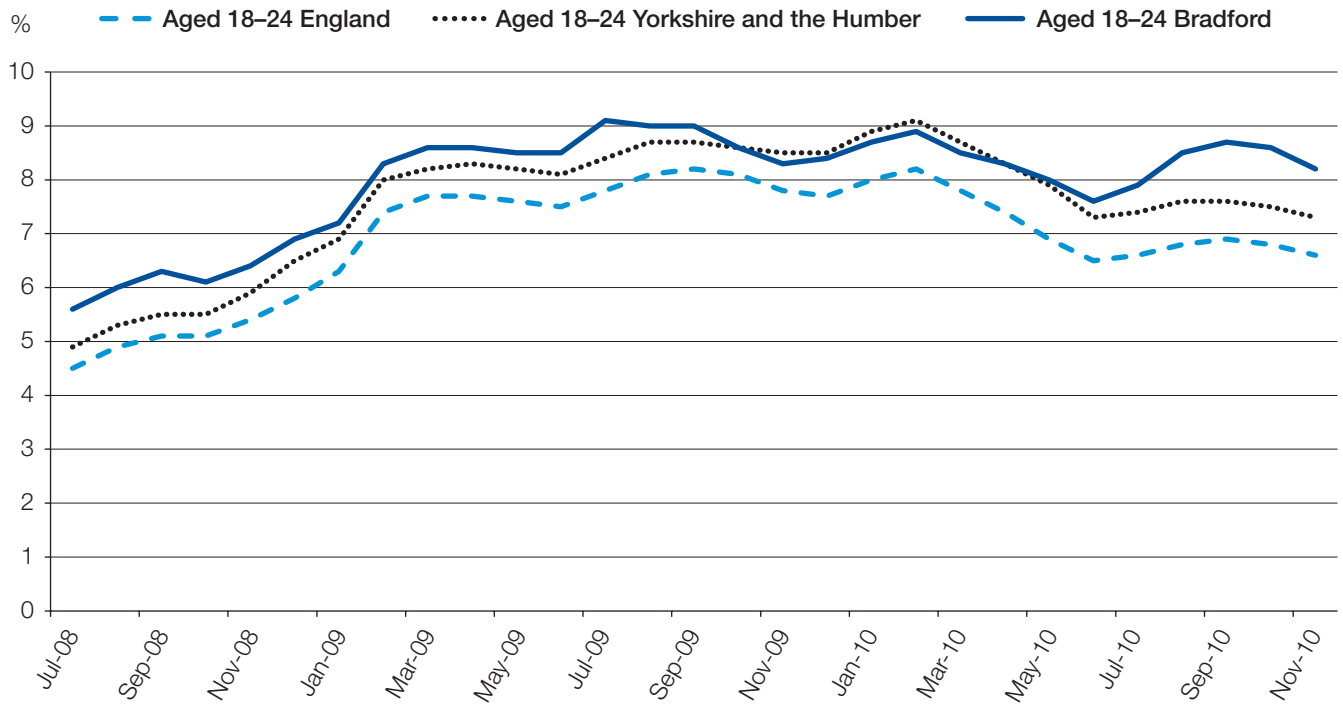
Figure 1: All people claiming JSA in Bradford, Yorkshire and the Humber and England between July 2008 and November 2010



Source: ONS claimant count

Notes: Age and duration with proportions. % is a proportion of resident population aged 16-64.

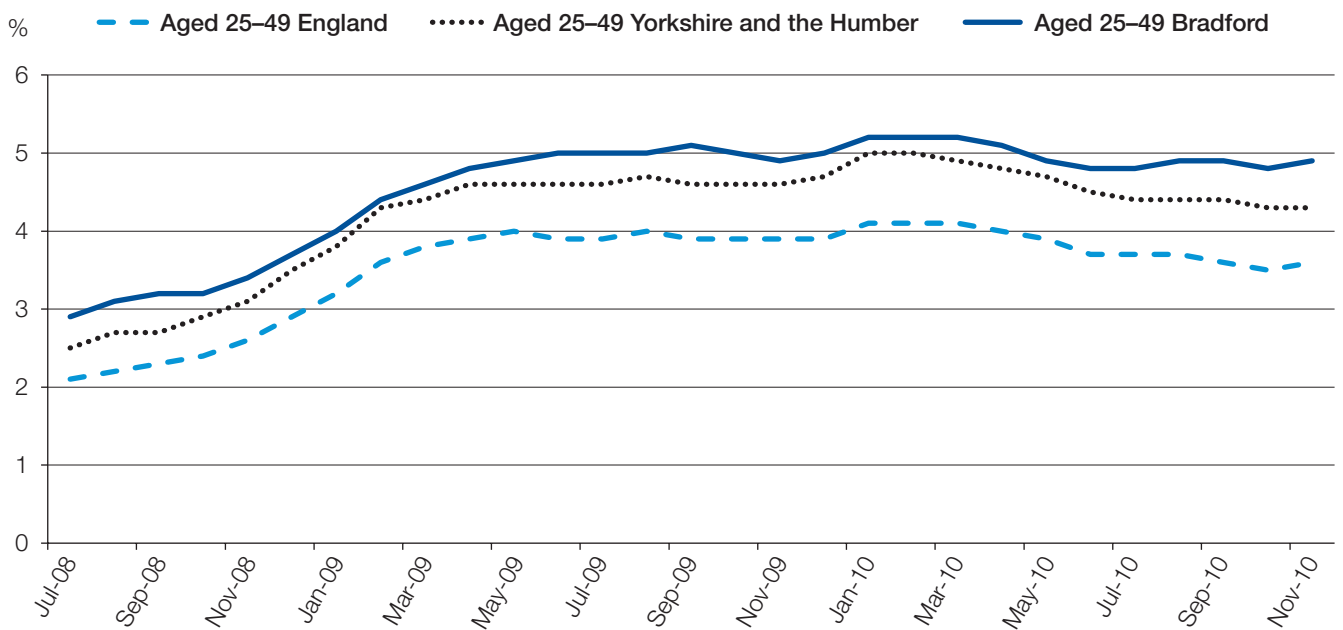
Figure 2: All people aged 18–24 claiming JSA in Bradford, Yorkshire and the Humber and England between July 2008 and November 2010



Source: ONS claimant count

Notes: Age and duration with proportions. % is a proportion of resident population aged 18–24.

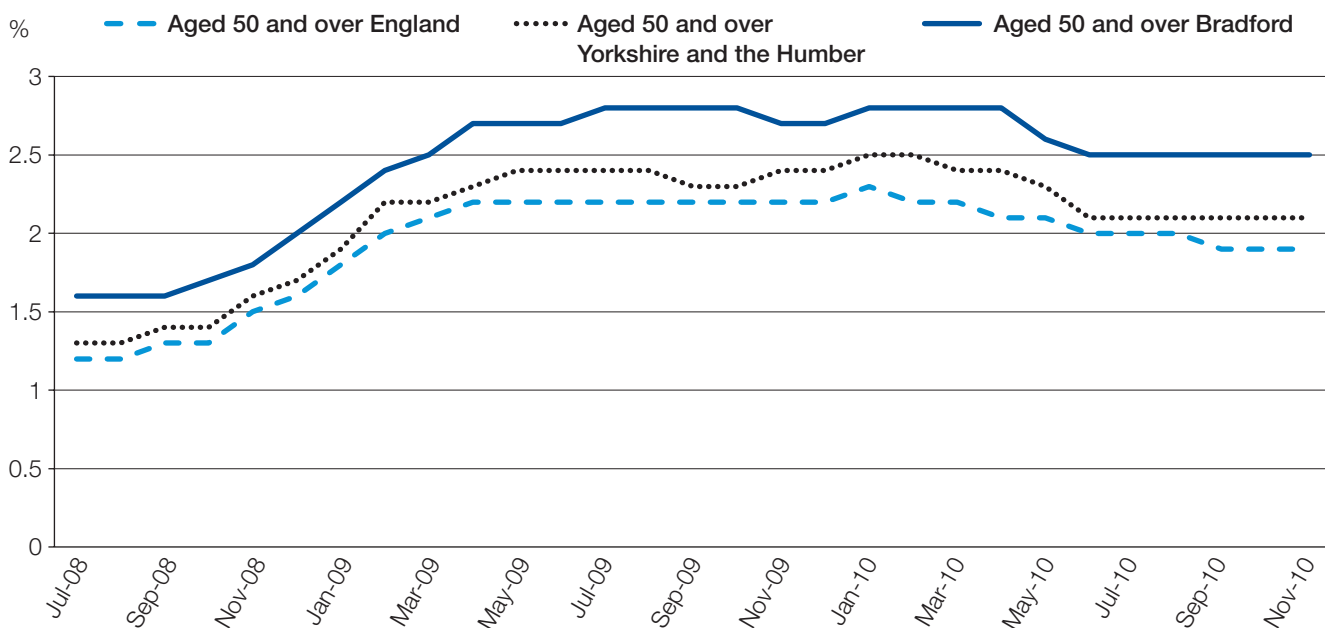
Figure 3: All people aged 25–49 claiming JSA in Bradford, Yorkshire and the Humber and England between July 2008 and November 2010



Source: ONS claimant count

Notes: Age and duration with proportions. % is a proportion of resident population aged 25–49.

Figure 4: All people aged 50 and over claiming JSA in Bradford, Yorkshire and the Humber and England between July 2008 and November 2010



Source: ONS claimant count

Notes: Age and duration with proportions. % is a proportion of resident population aged 50 and over.

Table 1: Prevalence of depression from April 2008 to March 2010 in Bradford, Yorkshire and the Humber and England

	QOF April 2008–March 2009 (%)	QOF April 2009–March 2010 (%)
Bradford	6.1	9.0
Yorkshire and the Humber	7.7	10.7
England	8.1	10.9

point. As mentioned earlier, the hypothesis whether the people of Bradford show elements of resilience comparatively to similar other localities cannot be checked through the QOF data.

Overall, the incidence of mental health disorders among the working-age population is expected to increase by 5–6 per cent between 2006 and 2012 in Bradford, broadly in line with the projected general population increase (Joint Director of Public Health Bradford and Airedale, 2009). The rise in unemployment rates and the job insecurity caused by the economic recession might potentially increase that percentage further.

Policy context

In March 2010 the Labour Government published *Confident Communities, Brighter Futures*, which opened the second phase of the Government’s ‘New Horizons’ vision on mental health (DH, 2010). This programme conceptualised mental health not only in terms of mental health problems, but also in terms of mental well-being. It was a cross-government and cross-sector programme of action that aimed to improve the mental health and well-being of the population, and to improve the quality and accessibility of services for people

with poor mental health (DH, 2010). It provided cost-effective approaches to promote well-being that could be implemented through local services in partnership.

In 2006 the Labour Government launched the Improving Access to Psychological Therapies (IAPT) programme, which was primarily aimed at supporting PCTs in implementing the National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders (see www.iapt.nhs.uk/about-iapt). As an evolution of this programme, in March 2009 a package of measures was announced to achieve a faster roll-out of talking therapy services across the country throughout 2009, and to allow health advisers on a dedicated NHS Direct phone line being trained to spot people who might be experiencing depression because of economic problems and refer them to help (British Association for Counselling & Psychotherapy, 2010).

At the time of the study, the above strategies and initiatives provided the policy framework for services and actions aimed at improving the mental health and well-being of the population at large, not only of individuals experiencing illness. However, in November 2010 the Coalition Government published the public health White Paper *Healthy Lives, Healthy People: Our strategy for public health in England* (Department of Health, 2010), in which mental health and physical health were given equal weight. In February 2011 the Coalition Government published *No Health Without Mental Health* (Department of Health, 2011), which replaced the Labour Government's 'New Horizons' strategy for mental health. This latter document supports the Coalition Government's aim of achieving parity of esteem between physical and mental health. It sets out the objectives to improve the mental health and well-being of the nation and to improve the outcomes for people with mental health problems.

At the local level, the annual report of the Joint Director of Public Health Bradford and Airedale (2009) stressed that 'New Horizons' required all stakeholders to view mental well-being as an investment rather than as a cost. However, it pointed out that its implementation might be challenging in a time of recession characterised by possibly reduced funding and increased demand on mental health services.

The mental health clinical pathway group of the NHS Yorkshire and the Humber Darzi review (2008) identified considerable variations in the region regarding the mental health services provided and the speed of their modernisation. It proposed the following recommendations (NHS Yorkshire and the Humber, 2009):

- help when it is needed – no queues;
- the adoption of a vision for mental health 'to live free from discrimination, disability and poverty';
- a single access point to ensure people get the right support quickly;
- investments in community mental health services to ensure capacity meets demand;
- mental health teams attached to GP practices;
- modernised dementia services.

The first five recommendations are relevant to the questions addressed in this study.

Organisation of the report

Chapter 2 offers a summary of the literature review on the impact of past economic recessions on health and well-being in the UK and other countries, with a particular focus on mental health and on interventions aimed at improving unemployed people's mental well-being and resilience. Chapter 3 reports the main findings of the qualitative analysis of the focus group interviews. Chapter 4 discusses the main policy and practice implications of the study findings.

2 Literature review: mental health at times of economic downturn and related interventions

This chapter offers a summary of the literature review undertaken to answer the following research questions:

- How does involuntary unemployment affect people's mental health?
- Does a contracting economy affect population health?
- What interventions have been used and which have proved effective to improve the mental well-being of those negatively affected by unemployment?

The first two research questions address an important distinction in the research literature on the relation between economic crises and health. The first aims at retrieving individual-level studies, which are concerned with the impact of unemployment on the mental health of individuals who have been exposed to involuntary job loss. The main focus of this report is on this group of people. The second research question aims at retrieving aggregate-level or ecological studies, which have investigated the relationship between macro-economic changes and indices of population health, such as indices of mortality, suicide and prevalence of psychological disorders. This literature shows that a number of countervailing mechanisms, for example, pre-existing levels of vulnerability and policy responses to the economic crisis, make the net effect of economic recessions on population health difficult to estimate and different from context to context.

The review is organised in three main sections, which reflect the three mentioned research questions: mental health and involuntary job loss, mental health at times of economic downturn and mental health promotion interventions. It informed and provided a context for the fieldwork stage of the study.

Mental health and involuntary job loss

A substantial body of literature shows that unemployment is negatively associated with mental health and well-being (see, among others, Murphy and Athanasou, 1999; Wanberg *et al.*, 2001; McKee-Ryan *et al.*, 2005; Waddell and Burton, 2006; Paul and Moser, 2009). In a recent meta-analytic investigation containing 237 cross-sectional and 87 longitudinal studies, Paul and Moser (2009) pointed out that the negative effect of unemployment on mental health² demonstrated in their study had considerable practical importance because it was 'equivalent to an increase in the rates of persons with psychological problems with potential clinical severity from 16% [among the employed] to 34% [among the unemployed]' (p. 278).

Overall, unemployment is a significant source of unhappiness and life dissatisfaction beyond its consequent income loss (see, for example, Winkelmann and Winkelmann, 1998; Di Tella *et al.*, 2001). However, recently Peiró (2006) showed that unemployment and income have a strong and negative association with life satisfaction, but not with happiness. These findings would suggest that happiness

would be relatively independent of economic factors, whereas life satisfaction would be conditioned by them.

In a 15-year longitudinal study of more than 24,000 individuals living in Germany, Lucas *et al.* (2004) showed that unemployment has an enduring impact on life satisfaction as it created a new set-point for life satisfaction. Set-point theories suggest that life events can have a negative impact on people's well-being; however, after an initial reaction, people return to baseline levels of well-being that are determined by personality factors. Lucas *et al.* (2004) showed that unemployment is one of the few life events (another is widowhood) that can change people's life satisfaction set-point. In particular, in Lucas' and colleagues' (2004) study, unemployed people did not return to their original life satisfaction baseline even many years after they regained employment.

Causal link

Research on the negative association between unemployment and mental health has also generated a growing body of evidence that shows that such relation might be causal (see, for example, McKee-Ryan *et al.*, 2005; Paul and Moser, 2009). Critics of this view, which is known as the 'causation hypothesis' (Schuring *et al.*, 2009), suggest that the association between job loss and poor mental health is explained by the fact that unemployed workers already had prior illnesses that made them more likely to become unemployed. This view, which is known as the 'health selection hypothesis' (Schuring *et al.*, 2009), has been particularly discussed in the literature on the relation between unemployment and risk of suicide. For example, in a Swedish study based on prospective information about risk factors for suicide from age ten years onwards in a large cohort of middle-aged men under risk of job loss during the 1990s recession, Lundin and Hemmingsson (2009) found that at least two thirds of the increased relative risk of suicide associated with becoming unemployed could be explained by a higher prevalence of mental illness or risk factors for mental illness. Lundin and Hemmingsson (2009) concluded that the excess risk of suicide among the unemployed in their study might not have been caused by the stresses associated with job loss. As will become clearer in the next section, causation hypothesis and health selection hypothesis might co-exist and manifest themselves at different economic times. Overall, several authors agree that, even after accounting for the link between prior illness and unemployment, a fraction of the association between unemployment and mental health problems is probably causal (see, for example, Gunnell *et al.*, 2009; Sharp, 2009). Nevertheless, there is not yet agreement on the mechanisms that mediate that relationship, nor on the factors that moderate the impact of unemployment on mental health. Different authors have suggested different mechanisms, some based on theoretical frameworks, some on empirical evidence. Examples of theoretically based mechanisms are Jahoda's (1982) latent deprivation model, Warr's (1987) vitamin model, Fryer's (1986) agency theory, Ezzy's (1993) middle range theory of status passage and Paul and Moser's (2006) incongruence hypothesis of unemployment distress. An example of an empirically driven mediating mechanism is that suggested by Price, Choi and Vinokur (2002). These theories and the literature on the factors that moderate the impact of unemployment on mental health will be briefly summarised in the two following subsections.

Mediating mechanisms

Jahoda's (1982) latent deprivation model and Warr's (1987) vitamin model are needs-based approaches. Jahoda (1982) suggested a functional model in which employment has both manifest benefits, mainly associated with financial remuneration, and latent benefits, which are associated with meeting five main psychological needs:

- having a time structure on the day;
- socialising with others;

- having a sense of purpose;
- knowing one's social status;
- being active.

According to Jahoda's (1982) theory, unemployment has pernicious consequences on people's mental health because it deprives them of a social institution, employment, which helps to meet basic psychological needs. Jahoda's (1982) theory has been criticised for ignoring people's interpretations of their job loss in accounting for their mental health and for disregarding that some forms of employment may not meet the five mentioned psychological needs, for example, alienating and oppressive work environments (Ezzy, 1993).

Using a medical analogy, Warr (1987) identified nine environmental features, or 'vitamins', which are important in determining mental health:

- opportunity for control;
- opportunity for skill use;
- externally generated goals;
- variety;
- environmental clarity;
- availability of money;
- physical security;
- opportunity for interpersonal contact;
- valued social position.

Warr's (1987) model suggests that social environments characterised by low levels of the above-mentioned 'vitamins', for example, the environment of unemployed people, lead to lowered levels of mental health. This theory is more complex than Jahoda's (1982) functional model and is able to account for the benefit that people may obtain from leaving oppressive working environments. However, social environments and their characteristics are the main drives in Warr's (1987) theory, which has been criticised for not addressing the interactions between the social environment and the meanings and interpretations that people give to them (Ezzy, 1993).

Fryer (1986) and Fryer and Payne (1984) recognise the important supportive role played by work. However, they criticise the passive nature of Jahoda's (1982) model and suggest viewing unemployed people as active agents whose beliefs, attitudes, intentions and goals are crucial to fully understand their experiences of unemployment.

Drawing on Glaser and Strauss' (1971) concept of 'status passage' and on identity theory (Strycker, 1980), Ezzy (1993) interprets unemployment as a process, particularly as a social transition between different types of social status. He suggests that this 'status passage' can entail a major disruption in people's striving to maintain a positive self-concept. So, while Jahoda's (1982) and Warr's (1987) models imply that unemployment generates stress because it prevents people from meeting basic psychological needs, Ezzy (1993) proposes that unemployment generates stress because it disrupts people's strategies to sustain consistent and positive self-images.

More recently, Paul and Moser (2006) have suggested an alternative hypothesis to Jahoda's (1982) and Warr's (1987) models. They propose that the distress unemployed people experience may be primarily caused by the incongruence between their values (high commitment to work) and their reality (no work), not by the fact that they do not work.

In a recent study, Price *et al.* (2002) found that financial strain and a reduction in personal control were the two main factors that mediated the impact of unemployment on people's mental health. Mediating factors have also been investigated in meta-analysis of the literature, which will be discussed in the following subsection.

Moderating factors

Several studies have investigated the factors that moderate the impact that unemployment has on the mental health of workers who lose their jobs, regardless of the causal mechanisms behind their stress. Such studies aim at identifying people who suffer more from unemployment distress and are in need of special help and people who suffer less and show resilient characteristics. Wanberg *et al.* (2001) identified five main moderators of the effects of unemployment on mental health:

- Financial resources: the worse people's economic hardship the higher the distress levels that they and their family experience.
- Employment commitment: the more having a job and working is central to a person's sense of self, the worse the impact of involuntary job loss.
- The ability to structure one's time: people's ability or inability to structure and plan their time during unemployment significantly affects their unemployment experience.
- Social support: people with higher social support during unemployment show higher psychological health.
- Coping techniques and methods: people's well-being can be affected by the coping strategies they engage in, for example, problem-focused coping strategies, like trying to look for a job, trying to manage one's financial situation, or emotion-focused coping strategies, like avoiding thinking of one's problem and focusing only on managing one's emotional response to stress.

In a meta analysis of 104 empirical studies on the impact of unemployment on unemployed people's psychological and physical well-being, McKee-Ryan *et al.* (2005) suggested several predictors of mental health³ based on five main categories:

- work role centrality: the general importance of the work role to people's sense of self;
- coping resources: personal coping resources, social coping resources, financial coping resources and time structure;
- cognitive appraisal: people's evaluation of their job loss, for example, stress appraisal, internal attribution and re-employment expectation;
- coping strategies: job search effort, problem-focused coping and emotion-focused coping;
- human capital and demographics: education, occupational status, age, gender, etc.

Work role centrality, stress appraisal, job search effort, higher number of dependents, longer unemployment and white ethnicity were found to be negatively related to mental health, whereas social support, financial coping strategies, positive employment expectations, problem-focused and emotion-focused coping, higher education, being married and female gender were positively associated with mental health. In particular, McKee-Ryan *et al.* (2005) found that the negative effects of unemployment on mental health were greater in studies with long-term unemployed people (>six months) than those with short-term unemployed people (≤ six months), and in studies with unemployed school leavers than in studies with unemployed adults. Similarly, Paul and Moser (2009) found that long-term unemployed people, young people and people older than 50 suffered more from unemployment than middle-aged people and those short-term unemployed. In contrast, Paul and Moser (2009) did not find that being in a relationship had a moderating effect on the impact of unemployment on mental health. Also, they found that men were more often distressed by unemployment than women.

A final reviewed factor moderating the impact of unemployment on mental health is overall unemployment rates. This type of research explored whether being unemployed during a period of economic boom was better or worse for the health of the unemployed compared to being unemployed in a period of high unemployment or recession. The literature reports contrasting findings on this. Some

studies have reported that the health of short-term unemployed people at times of economic downturn is worse than their health at times of economic boom, although this relation does not show among long-term unemployed people (see Novo *et al.*, 2000). Others have found that unemployed individuals at a time of economic boom show worse mental health compared to unemployed people at times of economic recession (see, for example, Scanlan and Bundy, 2009). In their meta analytic review, Paul and Moser (2009) found that unemployment had a stronger impact on mental health in countries with a weak level of economic development (measured through gross domestic product [GDP] per capita), unequal income distributions, or weak unemployment protection systems compared to other countries. However, McKee-Ryan *et al.* (2005) did not find any relation between levels of unemployment, availability of welfare protections for unemployment and the impact of unemployment on mental health.

Those studies that found a relation between low levels of unemployment and mental health suggested several hypotheses to explain this relationship. One of these is the ‘health selection’ hypothesis mentioned above. Others are that at times of low unemployment there might be increased feelings of self-blame and stigmatisation among unemployed people (see, for example, Rodríguez, 1997) or absence of ‘communities of support’ that may develop during times of high unemployment (see, for example, Jackson and Warr, 1987).

Mental health at times of economic downturn

The body of literature that has investigated the relation between macro-economic changes and population health has reported contrasting results. These vary depending on the health indicator investigated, whether mortality, suicide or psychiatric morbidity. This section summarises the findings of this literature in two subsections: mental health and suicide and mortality.

Mental health and suicide

Research shows that unemployed people are two to three times more at risk of death by suicide compared to fully employed people (see, among others, Platt, 1984; Blakely *et al.*, 2003; Gunnell *et al.*, 2009). In a study on the impact of the Asian economic crisis (1997–98) on suicide in Japan, Hong Kong, South Korea, Taiwan, Singapore and Thailand, Chang *et al.* (2009) showed a sharp increase in suicide mortality in some, but not all, of these countries. The sharp increases in suicide were most closely associated with rises in unemployment. So, while there were 10,400 more suicides in 1998 compared to 1997 in Japan, Hong Kong and Korea, these increases were not registered in Taiwan and Singapore, where the economic crisis had a smaller impact on GDP and unemployment (Chang *et al.*, 2009). Similarly, in a study on 26 European Union (EU) countries, Stuckler *et al.* (2009b) reported that rapid and large rises in unemployment were associated with short-term rises in suicides (and homicides) in working-age men and women. In these contexts, every 1 per cent increase in unemployment was associated with a 0.79 per cent rise in suicides at ages younger than 65. However, this effect was stronger in countries with low spending on active labour market programmes, and null or reversed in countries with high spending. Evidence that welfare support may offset the impact of unemployment on suicide was also offered in Howden-Chapman and colleagues’ (2005) comparative study on the impact of the recessions during the 1980s and 1990s in Finland and New Zealand. Despite the fact that unemployment rose to a greater extent in Finland than New Zealand, the increase in male suicides was smaller in Finland, where social spending rose as a percentage of GDP.

Mortality

Ecological studies that have investigated the relation between macro-economic change and mortality rates have given contrasting results. For example, Stuckler *et al.* (2009b) found that rises in unemployment

rates are associated with significant short-term increases in premature deaths from intentional violence, but reduced traffic fatalities. However, other authors have reported that total mortality is procyclical, meaning that total mortality and deaths from several common causes (for example, cardiovascular disease, influenza, pneumonia, liver disease and motor vehicle deaths) rise when labour markets temporarily strengthen (Neumayer, 2004; Granados and Tapia, 2005; Ruhm, 2005; Gerdtham and Ruhm, 2006). However, there is overall agreement in the literature that economic growth is inversely related to mortality in the long term, namely, over at least a decade (Brenner, 2005). This relationship explains the overall mortality rate decline over the twentieth century experienced in western countries. However, within the first few months of a decade of expansion, rapid economic growth is associated with increased mortality (Brenner, 2005). This means that the pace of overall decline in mortality is slower during phases of economic boom and faster during phases of economic downturn. In the last analysis, 'increased mortality associated with *transitory* strengthening of the labour market does not necessarily imply negative effects of *permanent* economic growth' (Gerdtham and Ruhm, 2006, p. 313).

Rising mortality rates during phases of economic expansion have been explained as a consequence of more intensive use of labour and the stress associated with the adaptation to new technologies. Another hypothesis suggested that socio-economically vulnerable populations might be disproportionately at risk of 'working themselves to death' during periods of economic expansion (Edwards, 2008). However, Edwards (2008) found that working-age men with higher education were more at risk of death during times of economic expansion, whereas those with little education experienced countercyclical⁴ mortality. Gerdtham and Ruhm (2006) found that procyclical⁵ fluctuations in total and specific causes of deaths were more pronounced for countries with weaker social insurance systems, as proxied by the percentage of GDP devoted to public social expenditure, than for those with stronger safety nets.

Mental health promotion interventions

Despite the wide body of literature investigating the impact of unemployment on mental health and well-being, there is scant research aimed at developing and evaluating the effectiveness of interventions to improve the mental well-being of unemployed people.

Overholser and Fisher (2009) interpret unemployment as a 'stressful life event', that is, a situation that drains or exceeds people's perceived ability to cope. They classify strategies to manage stress in three main theoretical perspectives:

- Psychiatric perspectives, which focus on the symptoms of emotional distress and label people's problems on the basis of the American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders* (4th edn) (DSM-IV). Interventions based on this perspective imply the use of psychotropic medications aimed at lifting a person's mood.
- Psychological interventions, which focus on the cognitive processes that translate life stress into emotional distress. Interventions based on this approach aim to help people to make adaptive changes in their cognitive appraisal and behavioural coping styles.
- Social interventions, which focus on broader societal factors that play important roles in stress and coping, for example, interpersonal functioning, occupational adjustment and agency resources that might be available to help people deal with their stressors, for example, job loss.

Overholser and Fisher (2009) suggest that the sadness, pessimism and sense of failure associated with job loss are best addressed through a combination of psychological approaches and social intervention strategies; they are not appropriately suppressed via medications. They therefore argue for a socio-psychological approach to improve the mental well-being of unemployed people at a time of economic

recession. This implies multi-agency interventions aimed at cultivating positive attitudes, realistic optimism and specific job retraining skills.

Three potential settings for interventions can be identified in the literature: primary healthcare, labour market programmes and the community.

Primary healthcare

In a recent review of the literature, Harris and Harris (2009) mentioned that the three most commonly used strategies used in primary healthcare to prevent, detect and manage the health problems of unemployed people were:

- raising GPs' awareness about the health problems of unemployed people;
- providing GPs with local information on levels and characteristics of unemployment;
- supporting GPs to act as referrers to employment and welfare services.

Harris and Harris (2009) mentioned that they could not determine the effectiveness of the above strategies used in the studies they reviewed because of their small nature and variable quality. They suggested two main types of initiatives as a basis for interventions and research (p. 121):

- health checks offered by GPs for people who are or become unemployed, with a focus on common health problems (for example, poor mental health and behavioural and biological risk factors for cardiovascular disease) and preventive care and management of conditions that could act as barriers to return to work (for example, drug and alcohol misuse); and
- social prescribing.

Social prescribing promotes the use of the voluntary sector within primary healthcare (South *et al.*, 2008). It involves signposting primary healthcare patients with non-clinical needs to local voluntary services, employment and welfare services available in their area, including support groups for people who are unemployed. There is growing evidence of the efficacy and cost-effectiveness of this approach (Friedli *et al.*, 2009).

In the UK, the initial evaluation of the two demonstration sites for the IAPT programme showed that at the end of treatment 5 per cent more of the treated population was in employment (range 4–10 per cent) and not on Statutory Sick Pay (Clark *et al.*, 2007).

Labour market programmes

A CBT intervention delivered through a labour market programme (Job Network Settings) in Sydney, Australia, was successful in improving the mental health of unemployed individuals in five small-scale trials (Harris *et al.*, 2009). However, the intervention proved difficult to scale up and evaluate comprehensively. Harris *et al.* (2009) conclude that, despite lack of evidence of their efficacy, labour market programmes represent an important setting in which to implement mental health promotion programmes for unemployed people because they can reach high-risk groups.

In a recent review of studies based on vocational programmes for unemployed people, Audhoe *et al.* (2009) discussed two interventions aimed at facilitating unemployed jobseekers to return to work and prevent possible negative mental health consequences of unemployment. These programmes were the US JOBS II intervention programme and the Finnish Tyohon job search training workshop, which is a version of JOBS II. They were both 'based on theories of active learning process, social modelling, gradual exposure to acquiring skills, and practice through role playing, providing preparedness against setbacks during the job search process' (Audhoe *et al.*, 2009, p. 9). Both programmes reported a significant effect

on re-employment and decreasing psychological distress compared to the control group. However, JOBS II reported a positive effect only for the subgroup of unemployed people with poor mental health, which implies that there is limited evidence for an effective intervention aimed at improving mental well-being for unemployed people at large (Audhoe *et al.*, 2009). Audhoe and colleagues (2009) call for more research to evaluate whether a focus on mental health would improve the effects of re-employment programmes. To this regard, they mentioned the encouraging findings of several randomised control trials on CBT interventions for certain physical diseases, for example, myocardial infarction and non-specific low back pain.

In an older study, Eden and Aviram (1993) evaluated training designed to boost general self-efficacy (GSE) on job search activity and on re-employment. The treatment increased re-employment among participants low in initial GSE but not among those with high GSE.

Community settings

This type of setting refers to the vast network of volunteer support groups and initiatives aimed at empowering people, such as, for example, the Community Health Champions initiative offered by the Altogether Better Programme (South *et al.*, 2010). Although no literature was found on interventions aimed at unemployed people based in this setting, research shows that empowering approaches are beneficial to people's mental health and well-being in work environments (Robinson *et al.*, 2010). Community settings can link with primary healthcare settings through social prescribing.

Summary

Research literature clearly shows that, at the individual level, unemployment is negatively related to people's mental health and well-being. At the macro level, research shows that at times of economic recession there are higher suicide rates in the population and higher mental health morbidity. However, all-cause mortality rates and certain specific mortality rates rise during phases of rapid economic expansion and slow down during phases of economic recession.

The literature consistently report that governments can actively reduce the impact of rising rates of unemployment on suicide and the mental health of unemployed people by adopting policies aimed at keeping and reintegrating workers in jobs (Stuckler *et al.*, 2009a, 2009b).

3 Experiences of unemployment, mental well-being and support during the recession in Bradford

This chapter reports on the findings of the study participants' experiences of unemployment during the economic recession and on the impact that this event had on their everyday life, mental well-being and quality of life. It is divided into four sections. The first describes the financial impact that job loss had on the study participants' everyday life. This was widely discussed across all focus groups. The second section investigates the impact of job loss on the study participants' mental well-being and it focuses on their main sources of stress. The last two sections look at elements of resilience and at factors that buffered the impact of unemployment on the participants' mental well-being. In particular, the third section explores the ways in which the study participants reacted to and coped with unemployment. The final section examines the study participants' views and experiences of help and support, both from their private social networks and from the statutory and voluntary sectors.

Financial impact of job loss

The study participants mentioned a plurality of changes to their everyday life brought about by their experiences of unemployment. Several of these were caused by the financial impact of unemployment. This manifested in a substantial loss of income that often led to significant changes to their lifestyles. The extent of such changes depended on two main factors: whether they received redundancy pay or had substantial savings, and whether they were able to receive help from their family or relevant others. In our sample, younger study participants were more reliant on the help and support they received from their families, whereas older study participants could often, but not always, rely on redundancy pay. Some study participants reported that they had not received what they were owed by their previous employers after a company had gone into liquidation. Others reported frustration that their redundancy pay could have an impact on their eligibility to receive means-tested unemployment benefits.

[After being laid off, six months ago] I declared my car off the road 'cos I couldn't afford the petrol and the insurance, and I've moved back home.... (focus group with females aged 18–25)

They think oh, you got paid a lump sum, you can rely on that, but what you got it's only like not even a year's wage [...] I'm getting not even what I were getting before, but I'm gonna manage. (focus group with males aged 26–49)

Because money was held back from our last company, I ended up in a situation where unfortunately [talks about difficult family relations] I ended up in a hostel.... (focus group with males aged 50–65, unemployed for five months)

Adjusting to the sudden income loss was consistently described as both challenging and a learning experience.

I've been unemployed since March, my biggest concern is financially and living 'cos Jobseeker's Allowance is only £64 a week and my direct debits a month just for gas, electric all the rest of it is £104 right? And I get £130 a fortnight. So one fortnight £104 is put aside straight away and then I've got £26/£28 to feed myself. (focus group with females aged 26–49)

You are actually thinking every day have I got enough [money] to last me two weeks. (focus group with males aged 50–65)

One minute you've got your wage coming in and you've got set things that have to come out of that wage and then as soon as you lose your job it basically feels like your whole life's just gone up in the air and you've got to sort it all back out again and then you've gotta learn how to survive on a lower income than what you were accustomed to. (focus group with females aged 18–25)

In order to cope with the financial strain, several study participants borrowed money from friends and family members. This could happen at any time: soon after they lost their job, after a few months, or when, for whatever reasons, a benefit payment was not processed. Borrowing money, however, often only postponed participants' problems. Some of them talked about the practice of borrowing money from 'loan shark companies' and the danger associated with it.

It is a real struggle and then if you end up borrow it [the money] off somebody, if you're in that situation where you can, by time your first wage comes that's gone and then you've got another month to go you know, you're kind of in a rolling, bit of a spin, it can soon easily spiral out of control. (focus group with males aged 26–49)

[Benefit payments were stopped because an important letter ended up at the wrong home address] I just had to borrow from [friends and family] and then of course when your money does come through, then you owe most of it out. (focus group with males aged 50–65)

A few people who I know, where I live, they use loan companies and voucher companies. They will get two hundred quid's worth of vouchers and have to pay four hundred pound back. They borrow off loan sharks. (focus group with males aged 26–49)

Some study participants had previous experiences of long-term unemployment. In these cases it was difficult to distinguish the financial impact of long-term poverty from that of the latest job loss. Some women who had previous experiences of long-term unemployment described the pernicious effects that living on benefits for a longer period of time had on their families:

I've been on the dole for over a year now, I've probably got at home four disconnection letters... A bill comes through the door and I don't even look at it. There's no point opening it because I can't even afford to look at it. I must owe out £1,000 in bills. At least. (focus group with males aged 50–65)

My little boy, he was a big lad. He put a lot of weight on.[...] Because he were living on chips and eggs and things that I could just buy that were cheap to get him by on and I felt really guilty because he started getting bullied at school about his weight you know. (focus group with females aged 26–49)

Impact of job loss and unemployment on mental well-being

The study participants discussed several ways in which the experience of first losing their job followed by the acquired status of unemployment had an impact on their mental well-being.⁶ In particular, six experiences that negatively affected the participants' mental well-being were discussed across all the focus group discussions and are explored here:

- financial strain;
- job market competition;
- loss of time structure and motivation;
- loss of social role;
- anger;
- stigma.

Financial strain and job market competition were two manifest consequences of, respectively, job loss and job loss at a time of economic recession. The remaining four experiences were the emotional and psycho-social consequences of involuntary job loss and acquiring the status of being unemployed.

Financial strain

One of the main sources of stress associated with the experience of unemployment was the financial strain caused by the subsequent income loss. Financial strain affected the study participants' mental well-being in two ways. On the one hand, there were the constant thoughts and fear of not having enough money to get by for the week or the month, especially for those who had family and children, which were major stressors. This form of stress often had additional effects on family relations:

Me and my missus nearly split up and everything over it 'cause of the lack of money, bills to pay.[...] It were very hard. It puts a big strain on your family, you know. (focus group with males aged 18–25)

On the other hand, financial strain curtailed the study participants' ability to engage with their goals and plans, whether short, medium or long term. This particular effect can be found expressed in some quotes from the previous chapter and in those quotes in which the participants compared their current situation to mere 'existence'. By this expression the participants meant to refer to the fact that, in their current situation, their main actions and goals were satisfying basic biological functions such as eating and sleeping, without having the financial capability to engage with wider goals:

It's an existence really, you're only existing, you're not really living [referring to the possibility to engage with wider goals]. (focus group with males aged 50–65)

You're existing, you're not living. (focus group with males aged 18–25)

I feel, you know, I'm getting nowhere. (focus group with females aged 18–25)

The longer the study participants lived 'on the dole', the worse their financial situation was and, so, the harder its impact on their mental well-being through those two mechanisms.

Loss of time structure, motivation and boredom

The study participants, regardless of their sex and age, often talked about the impact that unemployment had on their everyday life in terms of losing time structure and routine. This was discussed as a frustrating experience that eventually affected their motivation to get out of their home and to engage in social or other activities. Some study participants reported how, in their experience, such a feeling of lack of motivation and boredom degenerated into a pathological state that induced their loved ones to suggest they look for psychological help:

There were days when I didn't get out of bed and just days run into one, when you're unemployed. You don't know what day's what. All you know is your signing day, I suppose. For me personally anyway.

Just getting out of bed in the morning. Like, you've got nothing to do all day. I mean luckily I have a dog to keep me busy and my cat you know, 'cos they need looking after, but I got really depressed and started to find it really hard to get out of bed in the morning. (focus group with females aged 18–25)

I'd be up every morning and then I'd just be sat there. I'd be, like, well, I've got nought to do.

I wouldn't. I'm being honest, I'd just sleep. (focus group with males aged 26–49)

One hardest thing is the boredom factor because you've now got all the time in the world, but the problem is you've got no money.[..]

It was the same for me, I totally agree with what he said really. You've got a lot of time on your hands, you've no money.

[..] Sat looking at four walls is the most depressing thing in the world. The hardest thing is to fill the time, I go to library.

I go to the library too. (focus group with males aged 50–65)

The study participants used a variety of coping techniques to address this state of boredom and lack of motivation. These will be reviewed in more depth in the third section on resilience factors.

Loss of social role

The loss of social role that followed the study participants' job loss was another experience that had a negative impact on their mental well-being. Clearly, for many study participants work had a central role in building their sense of self. The loss of the work-related social role caused lower self-esteem in many of them:

As a professional [..] somebody who has been earning good money and just suddenly you are unemployed, you've lost your dignity... You've lost your morale, sometimes you recline to depression.... (focus group with males aged 50–65)

You feel like you're achieving something, don't you, going out and grafting?

Yeah. You get the end of the week and you feel a lot better about yourself.[..]

[When you loose all that] you just feel worthless, you know.

Yeah, it's an horrible feeling, it is. (focus group with males aged 18–25)

Involuntary job loss is only one type of transition from unemployment to non-employment, although very common during an economic recession. Other forms of transitions are retirement, return to education, maternity leave, family care and long-term illness (Thomas *et al.*, 2005). The main characteristic of involuntary job loss is that people do not have any control over it. While people might choose a change of social role in other forms of transition (for example, maternity leave or return to education), they are more likely to experience the change of social role caused by involuntary job loss as an unwanted change.

Anger

Several study participants, particularly the younger ones, experienced anger and rage, which often manifested in 'flipping' at other people. They often talked of how these feelings affected their relations with loved ones and were a cause of distress:

I realised that I were taking my anger out for me losing my job on the people that were closest to me, I felt as though I was hurting so why shouldn't other people.[...] Then in the end I thought well, it's not fair on them, just 'cos I'm hurting. It's no reason for me to give them my problems. (focus group 1 with females aged 18–25)

[...] 'cause I'd be really angry one day and then I'd just go and say, mum, I'm really sorry. I don't mean to be angry with you and we'd just talk. And then, I'd do it, like the same... I'd be doing it every week.[...] It's amazing how things change when you do get a job, how you just feel like a happier person. (focus group 2 with females aged 18–25)

He'd [the vignette's character] flip at someone. When I lost my job.[...] My brother goes to me oh, I told you you couldn't keep a job down, I said I don't see you working you [swearing ...] so I gripped closest thing to me and just whacked him with it man.[...] When you're stressed man, sometimes you do things you regret. Like next day I proper apologised to my brother.[...] But yeah, I think he'll [the vignette's character] lose it. (focus group with males aged 18–25)

Often anger and resentment were caused by experience of stigma.

Stigma

The study participants, regardless of their age and sex, talked extensively of the stigma that they felt attached to being unemployed and living on benefits. It is relevant to distinguish here between the concept of 'enacted stigma' and 'felt stigma' (Scambler, 2004). The concept of enacted stigma refers to episodes of actual discrimination experienced by the study participants on the grounds of the negative stereotypical views of unemployed people as lazy and unwilling to look for a job. The concept of felt stigma refers to both the shame associated with being unemployed and/or on the dole and the fear of encountering enacted stigma. Sometimes felt and enacted stigma was associated with the particular area of Bradford which the study participants came from. While some study participants reported episodes of enacted stigma, the vast majority talked of their felt stigma. Felt stigma and enacted stigma are both powerful sources of stress (Scambler, 2004). An example of enacted stigma was the following:

Believe me, they do look down on you when you're unemployed in a hostel [where this study participants temporarily lived after losing his job], because you get stigmatised, you get labelled as if you're either an absolute alcoholic or a drug user.[...] The trouble is people are on the doorstep [of the hostel] and when they get tanked up, the Asians who are driving up and down [...] Road they start with the verbal [abuse ...] you get labels as if you're all the same....

An example of felt stigma was:

Everyone just sees people on the dole as dole dossers.

Yeah.

That's it. It doesn't matter whether you're a nurse, you know, you're qualified to do something or whatever. You're just the same.

You're classed as a dole dosser.

I think it's just today's society. If you don't have a job, then you're just lower than everybody.

I think it's the areas you come from as well. It's what you see.

No, I don't really say that because I come off of an estate but I don't do the things that people might do on my estate.

Some older study participants talked about their felt stigma regarding their age. Others were not sure about this issue. In certain cases it was difficult to understand whether they had been actually discriminated in the job market because of their age (enacted stigma) or whether they feared they had been discriminated because of their age (felt stigma).

It's just really difficult from when you've worked for a lot of years and then suddenly you know, you're out of work again. And trying to get back into work now, I'm facing indirectly from two employers, I'm too old at 46.[...] I've been told I'm too old. I'm too experienced.

I've had that. I felt like that 'cos I've been for interviews. (focus group with females aged 26–49)

Another problem which actually has emerged, out of the recent industrial regulations is that once you've passed that age of 40 nobody wants to employ you.

I don't know if it's age that's causing the problem.... I mean for the last six months, four days I've been sending CVs off, I've been sending letters down London, anywhere [...] most of the employers don't even reply to you any more, which I find very incourteous. (focus group with males aged 50–65)

Job market competition

Often the study participants talked about the frustration of not being able to find a job due to the high number of competitors for each single job advertised. The frustration, sense of impotence and lack of control regarding this issue clearly affected their mental well-being:

You going down [to the job centre] week in, week out and there might be two or three jobs. By the time you've rung them, 40 people's rung them.

Yeah.

And, it's like, oh... And it gets to the point where you think, suck it man. What is the point? Because there's no work out there. (focus group with males aged 18–25)

I used to just go out sometimes and were just nearly crying because I'm thinking I don't want to do this [going to the job centre] but I can't find a job. There's nothing, nothing there for me. (focus group with females aged 18–25)

Resilience factors: coping strategies and fall-back roles

Several factors moderated the impact that the above-mentioned experiences had on the study participants' mental well-being. The two most frequently discussed were:

- personal resources and coping strategies;
- the practical help and emotional support that they received from their family and friends.

This section explores the personal resources and strategies that the study participants used to cope with the stress caused by being unemployed. These were categorised into two groups:

- coping strategies;
- fall-back roles.

The following section discusses the type of help and support that reduced the impact of unemployment on people's mental well-being and quality of life.

Coping strategies

Some study participants adopted problem-focused coping strategies to deal with the above-mentioned sources of stress. These consisted of a series of actions and behaviours that aimed at altering or managing the situation in which they found themselves (Julkunen, 2001). Examples of control-focused techniques were to keep trying to find a job and making plans of action. For example:

[I am] Just trying to keep positive in everyday life. Just waking up in the morning and I have a list of stuff to do now. I'll do this and do this and do this and then tick them off as I go and that's somat I've done today and my day's aren't just rolling into one. (focus group with females aged 18–25)

Because of my background in research, what I do sometimes is I sit down at my computer and do a bit of work... I'm always engaged, if I am not doing something I'm engaged with my computer and trying to do a piece of research, research into work, research into other things and research as to ... even becoming self-employed ... because that's the ultimate thing I think I have to do now, if at the end of the day I can't find work then I have to be self-employed, definitely.[..]

I can't do that because [I'm missing] his background [... mine] it was more mundane, more assembly work, so it's boring. So, most of my time really now is taking up looking for work.[..] I can either do that

or go round to do sort of handyman jobs, for the family, I do a little bit tinkering about on that.[...] (focus group with males aged 50–65)

Other study participants engaged in emotion-focused coping strategies. These consisted of activities aimed at reducing or managing emotional distress (Julkunen, 2001). Based on Latack's (1986) scale of coping, emotion-focused copings strategies were categorised into three types:

- control-oriented strategies, that is, searching for emotional support;
- escape or avoidance strategies, that is, denial, trying to forget the whole thing;
- 'symptom management', that is, exercise and relaxation.

Escape strategies included 'unhealthy' strategies such as excess drinking, smoking and taking illegal drugs.

The study participants' emotion-focused coping strategies differed on the basis of their gender and age. The majority of the male study participants tended to engage in avoidance or symptom management strategies, such as doing exercise, and showed reluctance to engage in searching for emotional support, that is, in control-oriented strategies. This led them to live their experience of unemployment as a 'private' issue, despite the common nature of the causes of their unemployment. On the other hand, women tended to look more actively for emotional support and they did not discuss examples of escape or symptom management strategies.

Pride and fear of appearing to be begging for money were the main causes of avoidance strategies and for not actively searching for emotional support among men, regardless of their age. Clearly, having a job was important not only financially, but also because it helped to fulfil the social role of breadwinner with which the study participants identified themselves. 'Complaining' about not having a job was seen as admitting failure with regard to that goal. Older male study participants referred to the strength of their character and to the view that 'men' do not talk about their personal problems; they "laugh them off" or "bottled them up". Both young and older men referred to their upbringing as the main cause of their negative attitude towards sharing their distress and emotional problems with others. However, one young study participant seemed to be more open to share his emotions:

I've got my pride.

Pride, innit, yeah.

I don't want no one to dent it and I won't want to dent it myself by saying, oh, yeah, I can't get a job, I'm useless, to somebody who'll be, like, what?

Shut up or something.

Shut up and get on with it. You know what I mean? That's my sort of background. It's, stop whinging and crack on, you know.

It's not as easy as that, is it?

No, it's not.[...] (focus group with males aged 18–25)

We're men aren't we? [...] You keep it to yourself, don't you?

It depends though, man, because you get some men that are in touch with their emotions, in't it, you know what I mean. (focus group with males aged 18–25)

I were raised in a family like that [in which men do not talk about their emotions].

[...] I don't talk about my issues.

And the same with me.

You laugh it off, men don't talk as if they were going to break down in tears, we laugh it off.

We laugh it off.[...]

Men always bottle things up.[...] I come from an ex-pit village and the same kind of scenario works in the pit village. Men tend to bottle things up, they don't tend to show their emotions.[...] That's the way you've been taught by your father or your brothers. I come from a family of ten so it's, you don't show your emotions at all. (focus group with males aged 50–65)

Despite the fact that the majority of men, regardless of their age, shared this common view about their masculinity, there was a main difference between younger and older study participants in their avoidance strategies. While younger study participants often mentioned using cannabis or getting intoxicated to cope with stress, with one exception none of the older study participants talked about abusing alcohol or taking illegal drugs to cope with their distress. Also, older study participants did not mention engaging with symptom management activities such as sport. Instead, some of them mentioned engaging in 'downward social comparison', a self-enhancement strategy that entails comparing oneself to people who are worse than us (Kohn and Smith, 2003).

Some women like to get in a hot bath with candles and bubbles and stuff like that. I prefer to smoke a joint, me.

That's the same with me. That's my way of dealing with it.

Some people go home and have eight cans, you know what I mean. (focus group with males aged 18–25)

I love my weed. That is the only thing that keeps me sane.[...] It stops me getting depressed and stressed and stuff man. (focus group with males aged 18–25)

I can start feeling sorry for myself and then I see a guy coming down the road in a wheelchair and I think well I've got no problem have I?

I've tried that myself, I know where you're coming from.[...] The other day I felt a little bit down and I saw this young lass [...] in a wheelchair and I thought well you never know do you? (focus group with males aged 50–65)

Several study participants, both younger and older, engaged with unhealthy avoidance coping strategies such as smoking. One older study participant mentioned drinking alcohol as a coping technique. Some younger study participants engaged both in symptom management coping strategies, such as going outdoors and playing sport, and in unhealthy coping strategies, for example, getting drunk or smoking

cannabis. Unhealthy coping strategies had an impact on the study participants' capacity to invest their limited resources in other ways.

I smoked 'cause there were nought to do. I were bored. I was so bored I were just smoking constantly. (focus group with females aged 18–25)

I reckon I spend on average a week less than £20 of my dole money on food, because I've got to smoke and, to keep sensible, I've got to go for a drink otherwise like you say looking at four walls and talking to myself... I'd be climbing up them. (focus group with males aged 50–65)

Interestingly, women, regardless of their age, shared this view that 'men' do not talk about their emotions. They attributed it both to an element of masculinity (it was not a "blokey" thing to do) and to the fact that men are expected to be breadwinners, so they cannot talk about their issues because that would mean admitting failure. Women, regardless of their age, viewed themselves as more open to sharing their emotional problems and stress with other women. They also often actively looked for emotional support from friends and relevant others when they needed it, which helped some of them to recover from depressive symptoms.

A lot of the time it is easier to talk to someone who hasn't got an idea what's going on. I ended up talking to one of my friends that I hadn't seen for a while and even she realised that there were somat not quite right. So I just sat and spoke to people about it and eventually I've got better and better and it's getting to the stage now where I can get up and do things and just carry on like I was when I was at work just without going to work every day. (focus group with females aged 18–25)

It's not a blokey thing to stand in the pub and go you know it's really doing my head in that I haven't got a job and I'm just sick of sitting in the house and watching da da da. They just don't do that you know. [...] Where women will sit down and.[...] Do you know I'm having a really shitty day 'cos I've written for so many jobs and I just can't get one and women will do that and fellahs won't. (focus group with females aged 26–49)

Fall-back role

Having a 'fall-back' social role, such as housekeeping, for females, parenthood and volunteering, for both males and females, was often helpful to compensate for the stress associated with the loss of work role and to give structure to the day:

I've got a little boy. I used to take him up my mum's, take him to parks. You know, in between looking for jobs, as well, but my days were mainly filled by my little lad, taking my little lad out.[...] (focus group with males aged 18–25)

I turned into this cleaning freak because I had nothing else to do.[...]

Yeah, I've done that started cleaning. Clean the house and then you get so bored that you start tidying your knickers drawer.[...] (focus group with females aged 26–49)

I used to volunteer when I were out of work.[...]

Yeah, I've done some volunteer work.[...] I've worked there previously, helping out now and again if I'm not doing nought.[...]

I'll go and have a game of footy. (focus group with males aged 18–25)

However, having a 'fall-back' role was not necessarily related to the type of coping strategy adopted by the study participants to deal with their other sources of stress. This was particularly the case among the younger study participants. Some of them fulfilled their roles as parents and then also either smoked cannabis or drank in excess.

Resilience factors: social support and access to services

This section explores the study participants' sources of support and their attitudes, views and experiences of services in relation to their mental well-being. It also reports the main themes that emerged from the interviews with the stakeholders of mental health and other related services in Bradford.

Help and support from family and friends

Those among the study participants who had a family, or who had contact with their families, stressed the importance of this source of support. Often families were the first and more important source of practical help and material support; they offered shelter and money when needed. However, not all of the study participants talked about family members as ideal sources of emotional support. Some study participants found their families a fundamental source of both practical and emotional support; others received material support, but not emotional support. In these latter cases, friends, or even unknown people, were indicated as better candidates to discuss problems with. Sometimes the study participants experienced at home the type of pressure and stigmatisation that are typical of enacted stigma and 'victim blaming'.

I used to go back and live with his [her partner's] parents a lot 'cos we were struggling with finances after my partner lost his job [she did not have contacts with her own family]. I went in and out of states of depression and I've just come off my depression tablets so I'm really happy about that.[...] I found talking to someone who was out of the picture, so to say, helped a lot.

Yeah 'cos they can't judge you.[...]

Yeah. Talking to a family member, they've got their two penny's worth to put in haven't they? They know the situation and that.

Yeah and if they're arguing they could bring it all up all the time. (focus group 1 with females aged 18–25)

If I think I've got a problem, if I need to talk to someone, I talk to my mum or my dad. (focus group with males aged 18–25)

They were angry at me 'cause ... well, my step dad 'cause he was saying, you should be doing more to find a job and I was getting angry 'cause I was applying for jobs and not hearing anything back, so there was a lot of arguing then.

No, mine [parents] were all right. It's my partner's that were, his mum were nagging him all the time. Which did annoy me as well. It's like, well, he's looking [for a job]. What else can he do? It does get annoying. (focus group 2 with females aged 18–25)

When you are unemployed sometimes you tend to live in a different world, you know ... either you are subjected to humiliation right from your family members, right from your wife, your child, your brothers ... you know. (focus group with males 50–65)

Often it was a close family member or friend who understood that the study participants had serious depressive symptoms and that they needed help. As seen in the previous section, women tended to be more active in looking for emotional support; however, they often shared the same type of views and reluctance as men when it came to accessing formal services.

Access to services: study participants' views and experiences

The experiences and views of the study participants regarding services are grouped into three main categories: job centres, doctors and voluntary and other relevant services.

Job centres

The study participants had contrasting views on the services they received from job centres. Several study participants were frustrated from having to wait six months before being able to receive full support to look for a job, including starting retraining courses. Among those who were enrolled in retraining courses, some found them useful; others demotivating and a waste of time. The main reason given for this was that all unemployed people were offered the same kind of courses regardless of their previous experiences and education.

Some study participants thought that they had not been given full information regarding the services available from the job centre, for example, about crisis loans or claiming for a bus pass. Others had been given that information. Some had learned about the service from each other at the focus group or had been told by friends or family members.

I never got told anything about crisis loans or anything when I were at the job centre.[...] I were actually eligible to claim for a bus pass for the first month because, it's a month in hand when you work and it were someone else that told me.[...]

It weren't like that with me.

[...] They didn't tell me, I had to hear it from my family.

I think I asked so many questions, that's why I probably know. [All laugh.] (focus group with females aged 18–25)

Overall, the study participants found the mechanisms of signing in every fortnight frustrating and stigmatising.

Doctors

Both males and females were reluctant to go to their GP to address their symptoms of depression and stress. The main reasons were that they did not want to be prescribed antidepressant tablets, which were seen as a source of stigma, and that they thought that the only solution to their problems was finding a job. One young woman who did go to her GP to ask for help for her depression was offered CBT, but was informed that there was a waiting list of ten months.

The last time I spoke to anybody they turned round to me and said you need to see a doctor, he says because you look clinically depressed. And I said well you know what's he going to do, give me

tablets? It's not going to help me. I said all they're doing is putting you into a label, they're giving you tablets like beta blockers, things like that which take all the emotion away and make you into a zombie, that's not what you want.

Worse thing you could do to yourself, start on that.[...]

*Because when you go to the GP what they do they class you as somebody clinically depressed.[...]
What somebody needs is a psychological comfort, somebody who knows your problem, who understands your problems and who is ready to talk to you about it. (focus group with males aged 50–65)*

[...] I got a letter through about three week ago from the [PCT] saying we've got a place for you to go on this CBT. It were twelve month ago I got referred by doctors. (focus group with females aged 18–25)

Other relevant services

Several study participants had a proactive approach to their financial problems and looked for practical help and support. Several used the Citizens' Advice Bureau services and found them helpful. A young woman was referred to a psychological consultant by the Job Shop, and she found that very helpful. However, none of the study participants mentioned other voluntary sectors services, such as those offered by Mind in Bradford, or Relate.

When the study participants were asked what services would ease their financial and emotional problems, several of them suggested two main options. With regard to financial problems, they suggested that those who could not afford to keep up with the payment of their utility bills should be given a chance to stop and postpone their payments for a while. As one woman put it:

If you lose your job and you get into debts you don't get the help from like the [utilities] companies 'cos you can ring them and tell them that you're struggling with your bills and they're still sending you the snotty letters and the nasty 'phone calls and it don't help people. (focus group with females aged 26–49)

With regard to emotional support, the quotes reported in this section show that many study participants found counselling services with people who they did not know beneficial for their mental well-being.

Mental health service provision in Bradford: stakeholders' views

Several common themes emerged from the individual interviews with the stakeholders of mental health and other support services in Bradford. These were categorised into three groups: themes related to the recession, to unemployment and to service provision.

With regard to the recession, the stakeholders from the statutory sector mentioned that strategic thinking was ongoing regarding how to address two main health and social effects of the economic recession:

- Its 'non-equalising' nature: it was expected that, similarly to the recessions of the 1980s and 1990s, the current recession would generate more social and health inequalities.
- The potential time lag between economic downturn/recovery and their impact on population health.

Rising rates of unemployment were discussed as a double source of concern:

- for their potential relationships with lifestyle risk factors such as rising alcohol consumption and smoking;
- for their potentially negative impact on the potential for people with a history of mental health problems to re-enter the job market.

Both statutory and voluntary sector stakeholders mentioned the wide variety of services available in Bradford to help people with mental health problems to maintain or re-enter work and to promote well-being in the general population. Bradford Metropolitan District Council published a comprehensive directory of these services in 2010. All the voluntary sector stakeholders mentioned facing rising demands for their services. However, it was not clear whether this was an effect of the economic recession or rather of strengthened cross-sector collaborations with the statutory sector.

Statutory sector stakeholders viewed mental well-being promotion as an important investment, but also as potentially controversial in terms of its cost-effectiveness. One stakeholder mentioned that gaps in the geographical spread of some of the services related to well-being promotion could be a potential weakness of the current service provision in Bradford. All the stakeholders mentioned that the stigma attached to mental health problems was a significant barrier to people accessing mental health services that needed intervention.

Summary

- Becoming unemployed had an almost immediate financial impact on the vast majority of the study participants. This manifested in a substantial loss of income that often led to significant changes to the participants' quality of life, including the inability to afford running a car, paying the rent, paying bills and, in some cases, buying fresh food.
- Unemployment negatively affected the participants' mental well-being primarily through six experiences: financial strain, loss of time structure and motivation, loss of social role, anger, stigma and job market competition.
- Two sets of resilience characteristics affected people's capacity to manage the effects of those stressors and address the main factors leading to them: their personal resources and coping strategies and the practical help and emotional support that they were able to access from their family and friends.
- Some study participants engaged in problem-focused coping strategies, which consisted of any behaviour aimed at re-entering work. All of the participants engaged in emotion-focused coping strategies. Both were important to maintain their mental well-being.
- Men were found to be reluctant to look for emotional support, whereas women were more open to share with relevant others their distress to find relief from it. Several young male study participants talked about abusing alcohol and taking illegal drugs to cope with their stress.
- Some study participants found their families a fundamental source of both practical and emotional support; others received material support, but not emotional support.
- Many study participants were reluctant to go to their GP to address their symptoms of depression and stress. The main reason was that they did not want to be prescribed antidepressant tablets, which were seen as a source of stigma.
- Participants had contrasting views on the services they received from the job centre. Several were frustrated from having to wait six months before being able to receive full support to look for a job.
- Many participants suggested that those who could not afford to keep up with the payment of their utility bills should be given a chance to stop and postpone their payments for a while.

- Several study participants said that talking with people outside their usual social networks and receiving psychological support was beneficial.
- The stakeholders interviewed as part of the study expressed several concerns regarding the impact of the economic recession on mental health services, such as the potential impact of the recession on the possibilities of people with a history of mental health problems to re-enter the job market, rising alcohol consumption and smoking and rising demand of mental health services in a context of reduced public funding.

4 Conclusions

This study set out to explore the impact of involuntary job loss at a time of economic recession on people's everyday life (their goals and lifestyle) and mental well-being (their morale, self-esteem and experience of distress). In particular, we explored whether there were gender differences and age differences, that is, younger unemployed people (18–25) versus older unemployed people (50–65), with regard to the study participants' experiences and sources of help for both practical and emotional support. The study involved 73 male and female study participants of mixed ethnic background, with the majority being white British.

The study identified six main experiences that had a major impact on the study participants' mental well-being. These were:

- financial strain caused by income loss;
- difficulty in finding a job due to the stronger market competition;
- loss of time structure in the day;
- loss of social role;
- anger and frustration for one's situation; and
- stigma attached to being unemployed.

The impact of these experiences on people's mental well-being was moderated by two main sets of resilience factors: their coping strategies and their social and emotional support. Some study participants engaged in problem-focused coping strategies, which research has shown to be important for successfully re-entering the job market (Julkunen, 2001). However, men were found to be reluctant to look for emotional support; women were more open to share their distress with relevant others in order to find relief from it. Research has shown that both emotion-focused coping strategies, particularly looking for emotional support, and problem-focused strategies are important for the mental well-being of unemployed people (Julkunen, 2001). Several young male study participants talked about abusing alcohol and taking illegal drugs to cope with their stress; these unhealthy coping strategies were not mentioned in other focus groups.

Families were referred to as a fundamental source of practical and material help; they were often able to offer shelter and money when needed. Nonetheless, not all the study participants had a family to rely on. Also, not all the study participants found family members the best people to turn to for sharing their stress and unemployment-related problems.

This study indicates the need to help unemployed people to increase their coping strategies to mitigate the financial impact of income loss and debt on their everyday life and mental well-being. It also indicates the need to raise awareness regarding the stigma that the study participants felt was associated with unemployment and living in particular housing estates in Bradford. Stigma in relation to mental illness was also one of the main causes of the study participants' reluctance to turn to their GPs to ask for help with regard to their stress and depression.

Overall, these findings are consistent with those from the mainstream literature reviewed in Chapter 2. They contribute to the investigation of how gender and age moderate the impact of unemployment on people's mental well-being. This study has highlighted five main issues that require further policy attention:

- the need to address the financial burden of debt on people's everyday life;
- the need to facilitate emotional and psychological support for unemployed people (including stigma), particularly for unemployed men;
- the need to improve people's ability to keep a structure and routine to the day;
- the need to address the 'unhealthy' coping strategies adopted by some young unemployed men;
- the need to raise public awareness of the impacts of unemployment and hence attempting to reduce the stigma associated with both unemployment and mental ill health.

The literature on the relationship between macro-economic changes and population health shows that governments can have a crucial role in buffering the effects of unemployment on suicide and on unemployed people's mental health by adopting policies that maintain and reintegrate people at work.

At the local level, the following interventions could also help to address these issues:

- further expanding public interventions aimed at reducing the burden of debt on people's everyday life;
- developing Work Clubs, a recent DWP initiative which 'aims to support the development of a network of locally led, community based support for the unemployed which will grow organically across the country' (DWP, 2010, second paragraph);
- expanding the social prescribing service that is currently only available in one of the four practice-based commissioning alliances in Bradford (that is, Bradford South and West Practice-based Commissioning Alliance);
- reducing the long waiting lists that are currently characterising CBT counselling;
- strengthening cross-sector collaborations aimed at early diagnosis and early interventions for people who develop mental health problems while unemployed;
- strengthening existing services aimed at helping people with a history of mental health problems to re-enter work;
- ensuring geographical spread of services and initiatives aimed at promoting mental health, well-being and resilience.

These recommendations are consistent with the *No Health Without Mental Health* policy framework, which aims at promoting mental well-being in the society at large and at improving access to services for those who have been diagnosed with a mental health disorder (DH, 2011). They suggest interventions in the three settings that were reviewed in Chapter 2: in the community through Work Clubs, in primary care through social prescribing services, and in occupational services through information giving. These are particularly important given that unemployment rates could rise again due to a wave of redundancies in the public sector, particularly in a city like Bradford, which has a high rate of employees in the public sector.

Considering the reduced funding that the public sector will be facing in the coming years, it is important to stress two issues related to the delivery of the above-mentioned interventions. First, such interventions could put a strain on the resources of the voluntary organisations that would be involved in their organisation and delivery. So more resources might be needed to expand the capacity of the voluntary sector to support and run community-based initiatives in Bradford. Second, several study participants referred to libraries, parks and other public places across the Bradford District as important parts of their strategies to keep a structure to the day and engage in valued activities. These services, although non-statutory, are of fundamental importance for people's resilience, especially at times of economic recession, and may be subject to cuts in the forthcoming period.

Notes

1. Personal communication of the first author with the Enquiries Office of the NHS Information Centre.
2. Paul and Moser (2009) operationalised the concept of mental health through the following six indicators: mixed symptoms of distress, depression, anxiety, psychosomatic symptoms, subjective well-being and self-esteem.
3. McKee-Ryan *et al.* (2005) operationalised mental health through measures of both negative affect – for example, sadness, anxiety, depression – and positive affect – for example, joy, elation, happiness – although they pointed out that the former were far more common in the job literature than the latter.
4. An outcome is countercyclical if it decreases when the economy strengthens.
5. An outcome is procyclical if it increases when the economy strengthens.
6. In this study mental well-being is defined as ‘a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment’ (DH, 2010, p. 12). See Chapter 1.

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Appendix I

Methods – literature review

The review used four main techniques to identify relevant material:

- Electronic searching from 2000 to 2010 of the following five databases: ASSIA (Applied Social Sciences Index and Abstracts), PsycINFO, Cinahl, Web of Science and PubMed.
- Use of websites of relevant research organisations, for example, JRF website and the Cochrane Collaboration website.
- Tracking references and authors names from the retrieved papers.
- Additional web searching and identification of papers in a non-systematic way by team members on the basis of their field expertise.

The electronic searches were performed using relevant wildcard characters (for example ‘*’) on combinations of terms referring to:

- recession and unemployment (for example, recession, downturn, unemployment)
- interventions (for example, intervention*)
- mental health and well-being (for example, mental health, well-being and quality of life)
- policies and strategies.

The searches highlighted a paucity of studies on interventions aimed at improving the mental well-being of unemployed people.

Appendix II

Characteristics of the study participants recruited for the focus group interviews

Table 2: Study participants' gender

	Frequency	%
Males	33	45.2
Females	40	54.8
Missing values	0	0
Total	73	100

Table 3: Study participants' age groups

	Frequency	%
17–25	37	50.7
26–49	19	26.0
50–65	13	17.8
Missing values	4	5.5
Total	73	100.0

Table 4: Study participants' ethnic backgrounds

	Frequency	%
White British	62	84.9
Any other White background	1	1.4
Mixed White and Black Caribbean	1	1.4
Mixed White and Black African	2	2.7
Mixed White and Asian	2	2.7
Asian or Asian British Pakistani	1	1.4
Missing values	4	5.5
Total	73	100

Table 5: Study participants' area of residence in Bradford

	Frequency	%
BD1–BD3, BD4 (City and Bowling)	16	21.9
BD5, BD6, BD7 (Great Horton)	5	6.8
BD8–BD9 (Manningham)	4	5.5
BD 10, BD18 (Shipley)	32	43.8
BD13, BD15, BD17, BD20, BD28	9	12.3
Missing values	7	9.6
Total	73	100

Table 6: Study participants' highest education qualification

	Frequency	%
School (GCSE/NVQ1/NVQ2)	28	38.4
A-level or equivalent (NVQ3)	7	9.6
Graduate (BA/BSc)	0	0
Post-graduate (MA/MSc/PhD)	2	2.7
Professional qualifications	2	2.7
None	12	16.4
Other	14	19.2
Missing values	8	11
Total	73	100

Table 7: Study participants' social class

	Frequency	%
First class	14	19.2
Second class	8	11
Third class	1	1.4
Fourth class	10	13.7
Fifth class	33	45.2
Missing values	7	9.6
Total	73	100

Notes: Social class determined using the five-class self-completion version of National Statistics Socio-economic Classification (NS-SEC), available from: www.ons.gov.uk/about-statistics/classifications/current/ns-sec/self-coded/index.html

Table 8: Study participants who had been unemployed previously

	Frequency	%
Yes	57	78.1
No	12	16.4
Missing values	4	5.5
Total	73	100

Table 9: Study participants' length of unemployment

	Frequency	%
1–3 months	3	4.1
4–6 months	6	8.2
>6 months	56	76.7
Missing values	8	11
Total	73	100

Table 10: Study participants with a mental health condition

	Frequency	%
Yes	16	21.9
No	53	72.6
Missing values	4	5.5
Total	73	100

Table 11: Year of diagnosis with mental health condition

	Frequency
1995	1
1998	1
2000	1
2003	1
2004	2
2007	2
2008	3
2009	4
2010	1
Total	16

Table 12: Types of mental health conditions

	Frequency	%
Depression	6	37.5
Depression and anxiety	10	62.5
Total	16	100

Appendix III

Methods – qualitative data analysis

The following procedure was followed to keep the data analysis as open as possible to all of the information contained in the transcripts of both the focus groups and the individual interviews with stakeholders. The description provided below refers to the procedure followed for the analysis of the focus group interviews; however, the sample principles were also used for the analysis of the individual interviews with the stakeholder.

The computer-assisted qualitative data analysis software NVivo 8.0 (QSR International, 2009) was used to organise and help with the systematic exploration of the interview transcripts.

- The transcripts were first read in full in order to obtain an overall picture of the contents and, where needed, the audio files of the recorded interviews listened again.
- Statements and discussions that expressed ideas related to the topics being studied were coded, namely highlighted and stored as retrievable text in a 'node' (that is a category) created in NVivo. Each node expressed a distinct set of participants' views related to the study objectives; examples were: 'impact on everyday life' – which had a number of 'subnodes' such as 'emotional impact', 'feeling judged by society', 'financial issues', 'impact on family', 'loss of time structure' and 'socially isolated' – and 'coping strategies', which had two subnodes: 'strategies perceived to be healthy' and 'strategies perceived to be unhealthy'.

The transcripts were first coded by the third author. In addition, for validity purposes, the interviews were also coded by the first author and the codes compared to identify and discuss any possible disagreement.

- The transcript extracts contained in each node were then retrieved and analysed. These analyses had a twofold goal:
 - To investigate whether the content of the discussions differed depending on the gender and the age group of the participants in the focus groups. This was achieved by:
 - checking whether the transcript extracts were also coded at other relevant nodes, for example 'gender issues', and
 - checking what focus groups were coded at each specific 'node'.If, within a specific node, differences were identified based on the gender or age of the participants in the focus groups, then specific subnodes were created to emphasise them.
 - To investigate whether some nodes were redundant or expressed views that were similar or overlapping with those found in other nodes. Some nodes were comprehensive enough to represent themes on their own; examples were the nodes 'loss of time structure' and 'financial impact', which collected views that cut across all the study participants, regardless of their age or sex. Other nodes were merged together in a new, more comprehensive one that expressed an overarching theme that cut across them. For example, the theme 'anger and frustration for one's situation' expressed participants' views found in the nodes 'emotional impact' and 'impact on family'.

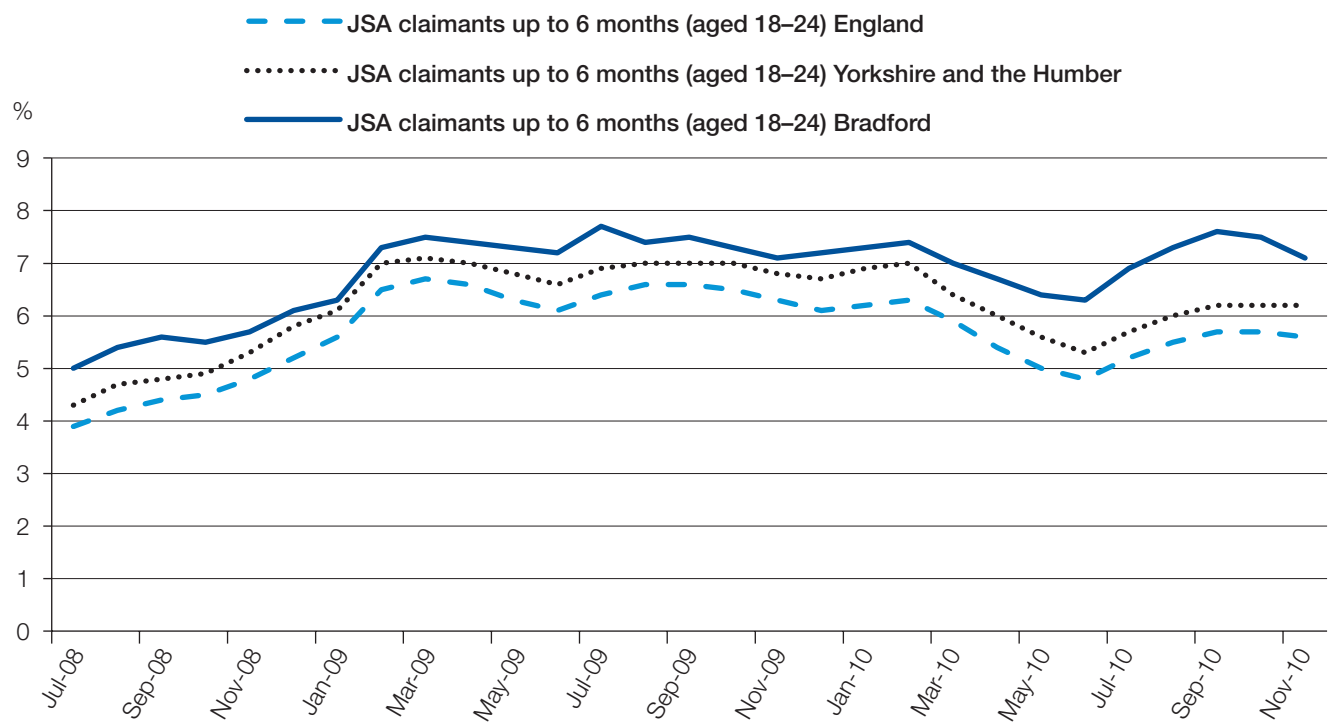
The above analyses were undertaken by the first author and then, for validity purposes, the themes identified were discussed and reviewed among all of the report's authors.

Appendix IV

Jobseeker's Allowance claimants' rates by age groups in Bradford, Yorkshire and the Humber, and England between July 2008 and November 2010

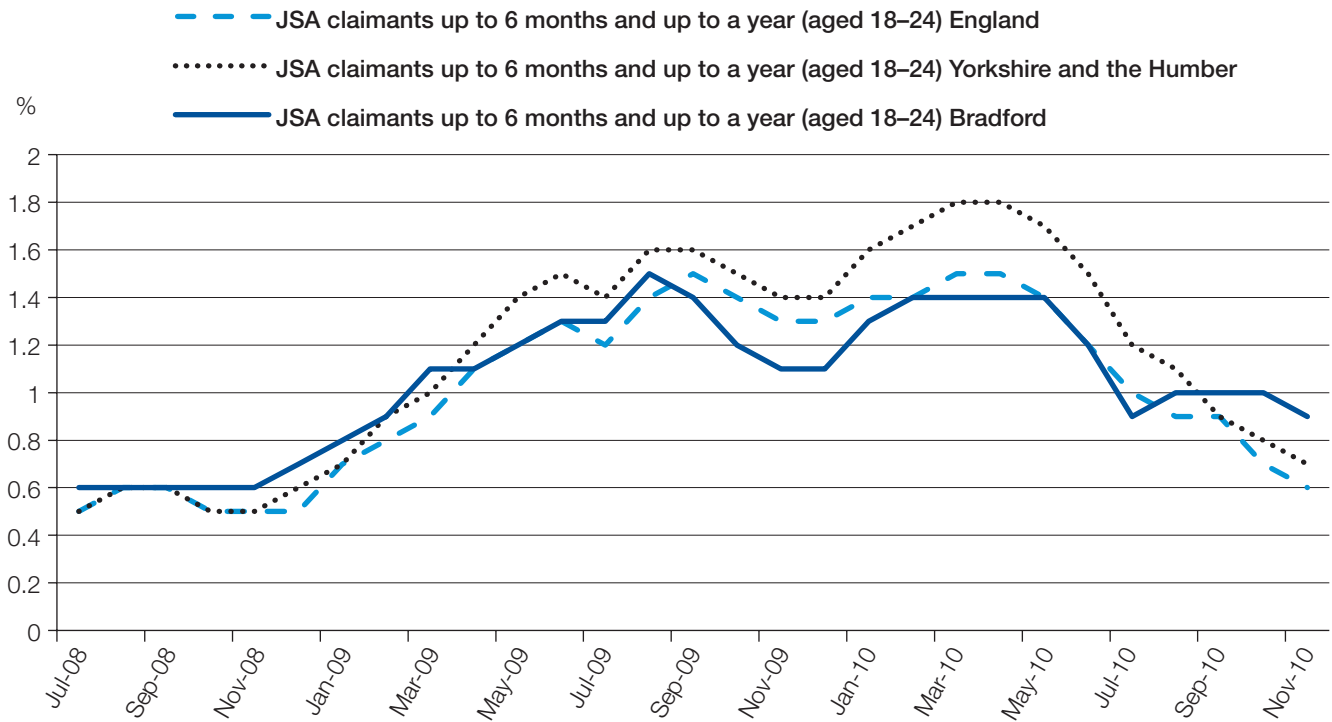
The source for all figures is the Nomis website (www.nomisweb.co.uk). The percentages in each figure are a proportion of the resident population of the relevant age group.

Figure 5: All people aged 18–24 claiming JSA for up to six months in Bradford, Yorkshire and the Humber and England between July 2008 and November 2010



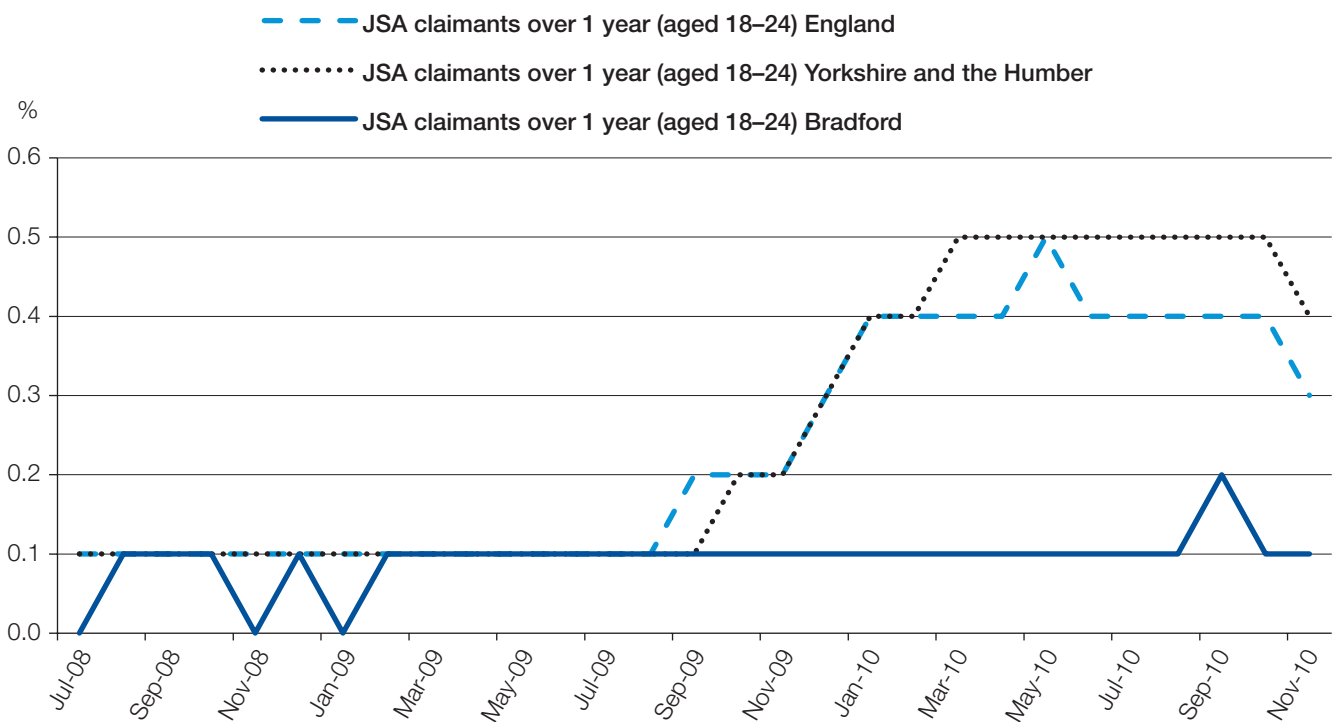
Source: ONS claimant count
 Notes: Age and duration with proportions.

Figure 6: All people aged 18–24 claiming JSA for over six months and up to one year in Bradford, Yorkshire and the Humber and England between July 2008 and November 2010



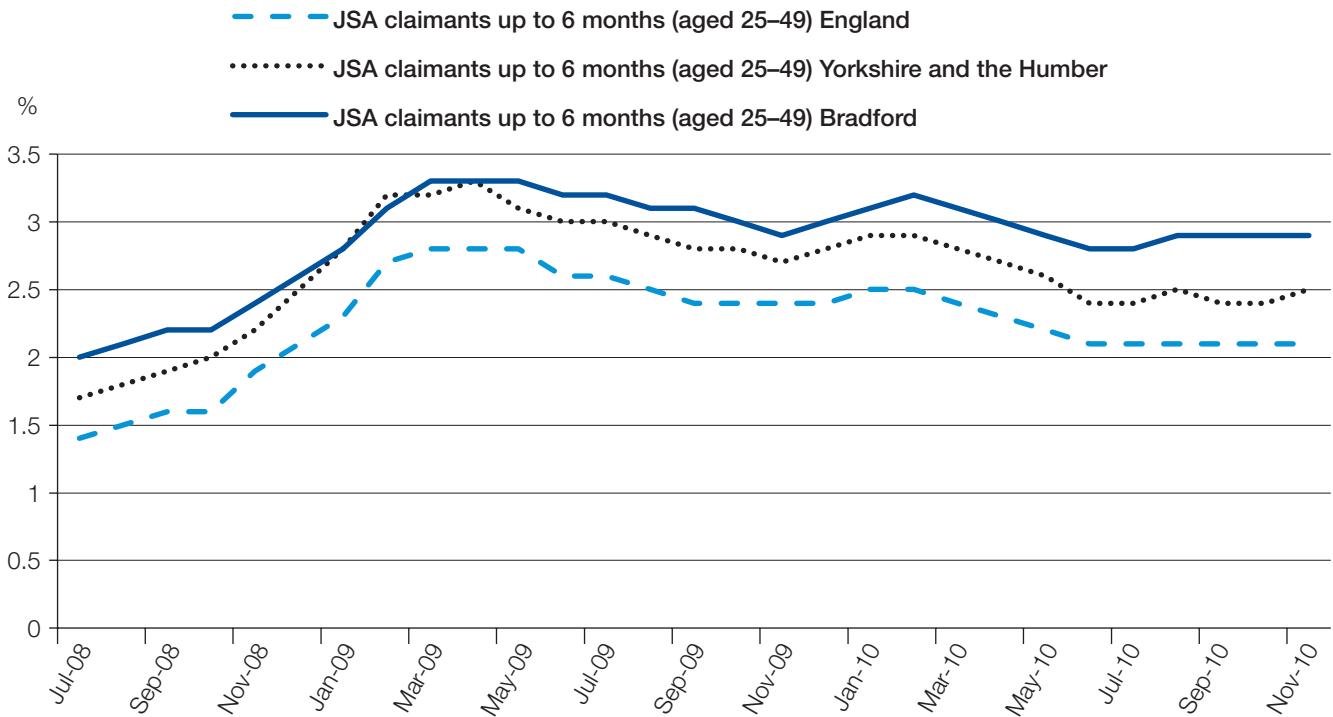
Source: ONS claimant count
Notes: Age and duration with proportions.

Figure 7: All people aged 18–24 claiming JSA for over one year in Bradford, Yorkshire and the Humber and England between July 2008 and November 2010



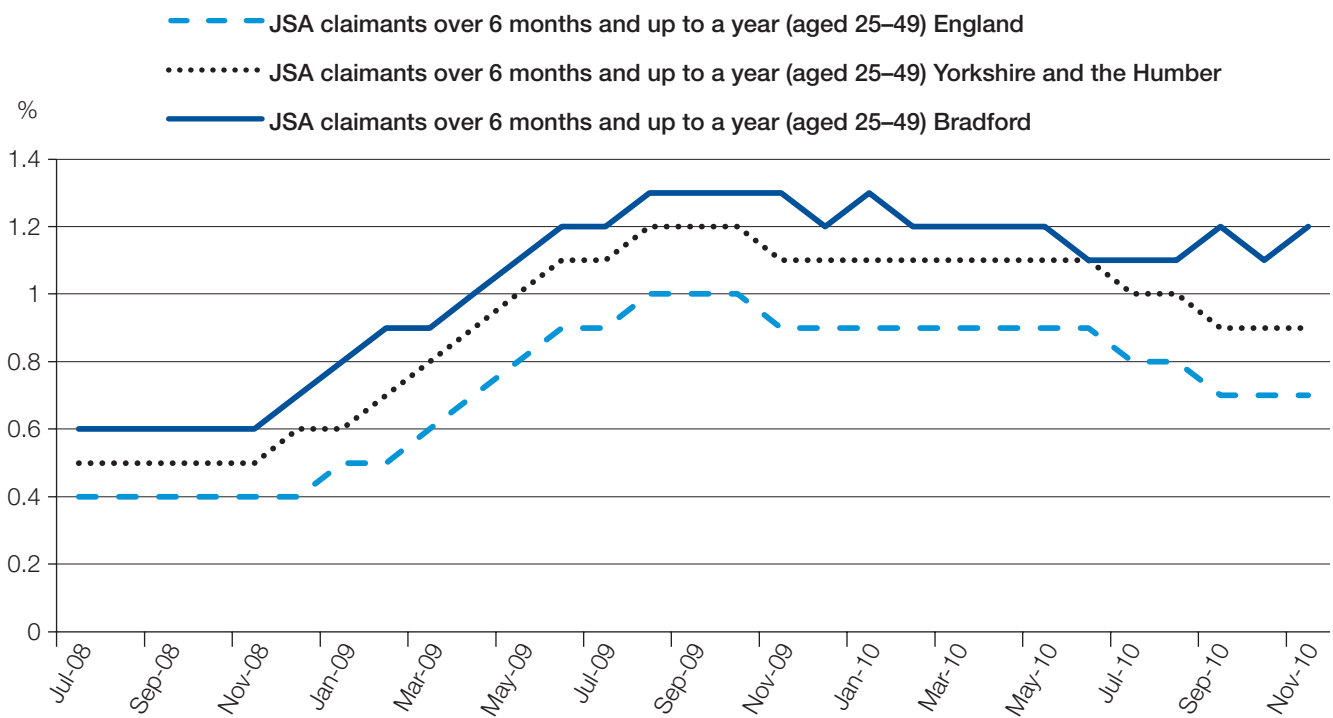
Source: ONS claimant count
Notes: Age and duration with proportions.

Figure 8: All people aged 25–49 claiming JSA for up to six months in Bradford, Yorkshire and the Humber and England between July 2008 and November 2010



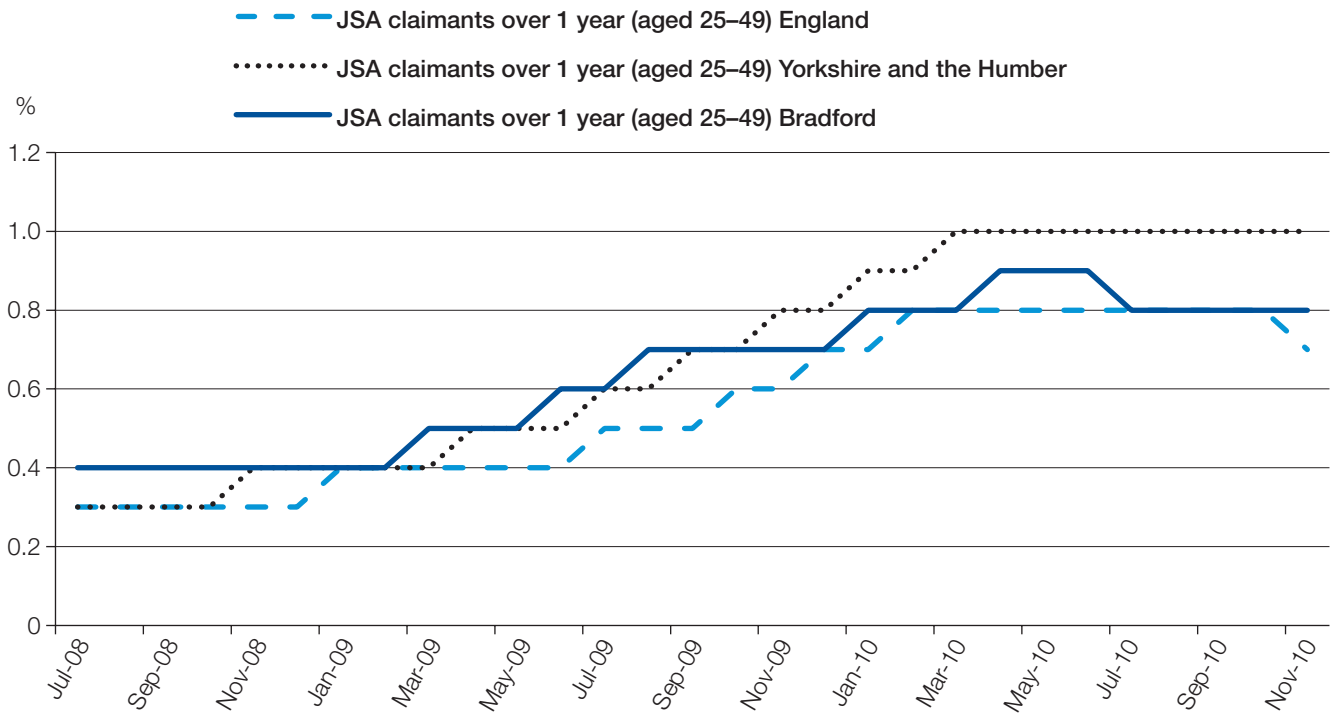
Source: ONS claimant count
Notes: Age and duration with proportions.

Figure 9: All people aged 25–49 claiming JSA for over six months and up to one year in Bradford, Yorkshire and the Humber and England between July 2008 and November 2010



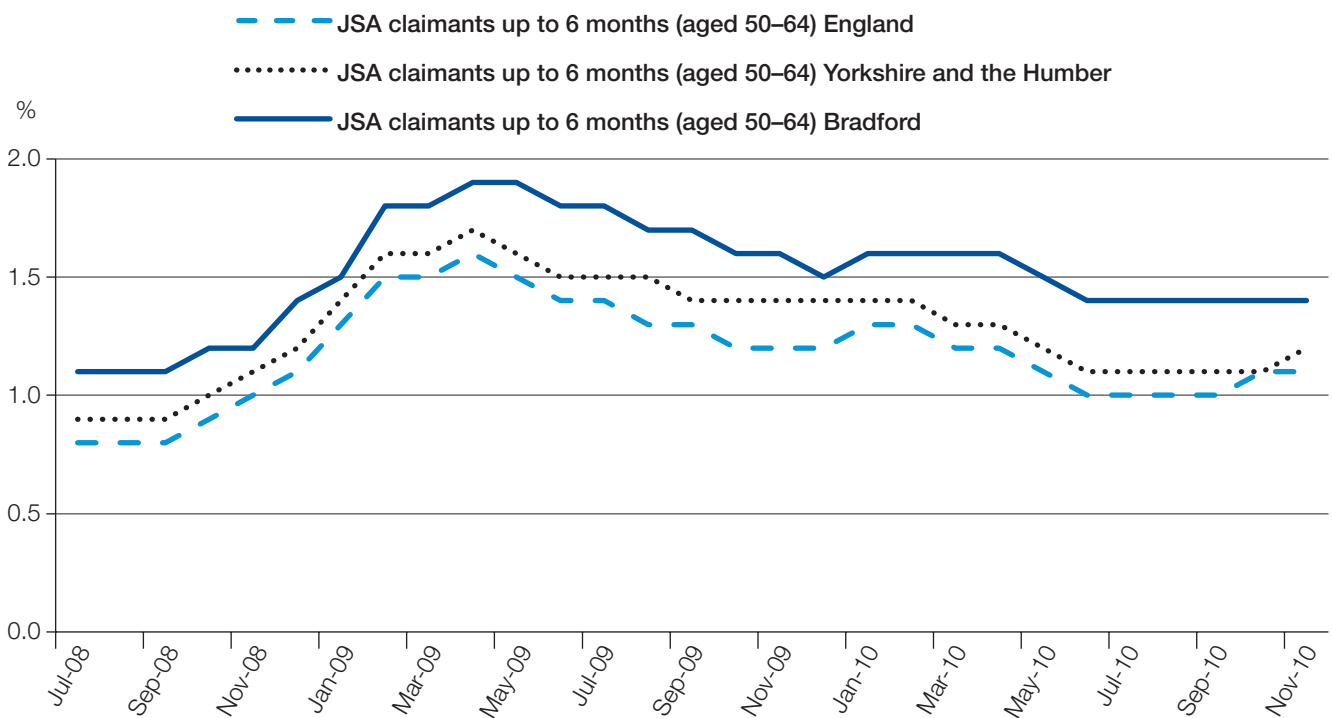
Source: ONS claimant count
Notes: Age and duration with proportions.

Figure 10: All people aged 25–49 claiming JSA for over one year in Bradford, Yorkshire and the Humber and England between July 2008 and November 2010



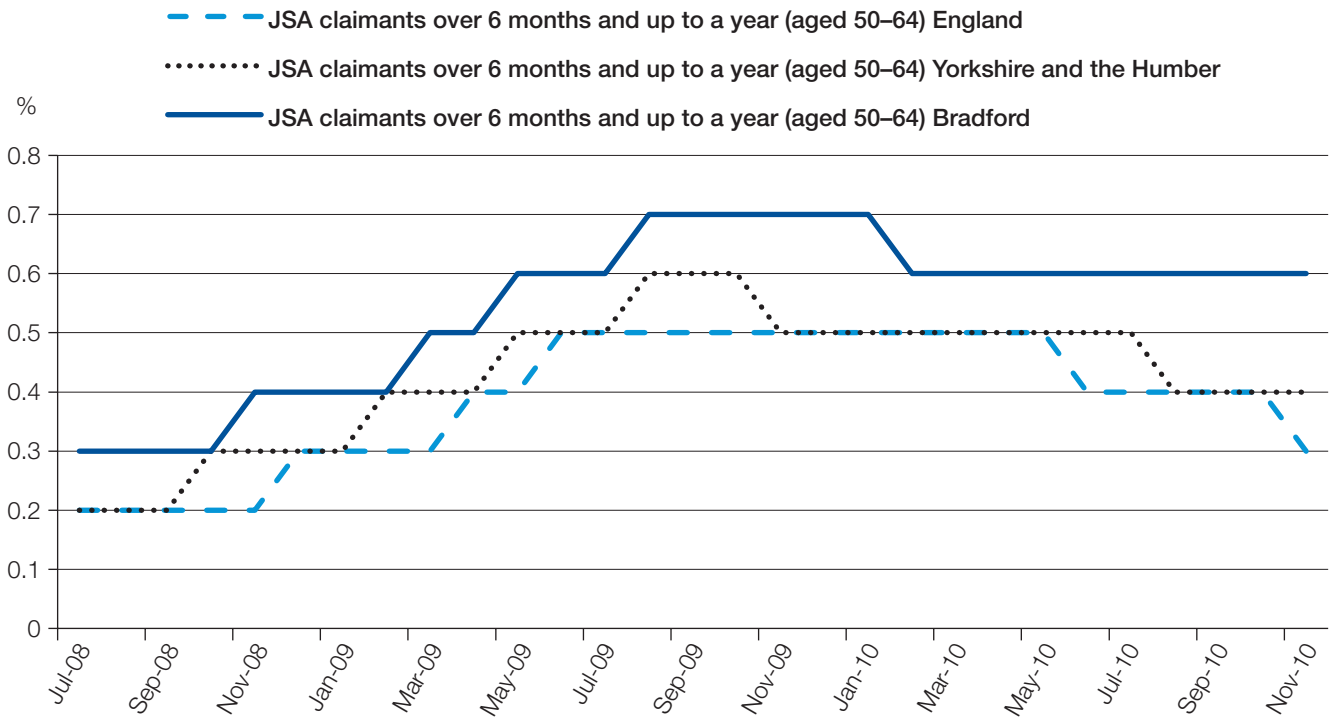
Source: ONS claimant count
Notes: Age and duration with proportions.

Figure 11: All people aged 50–64 claiming JSA for up to six months in Bradford, Yorkshire and the Humber and England between July 2008 and November 2010



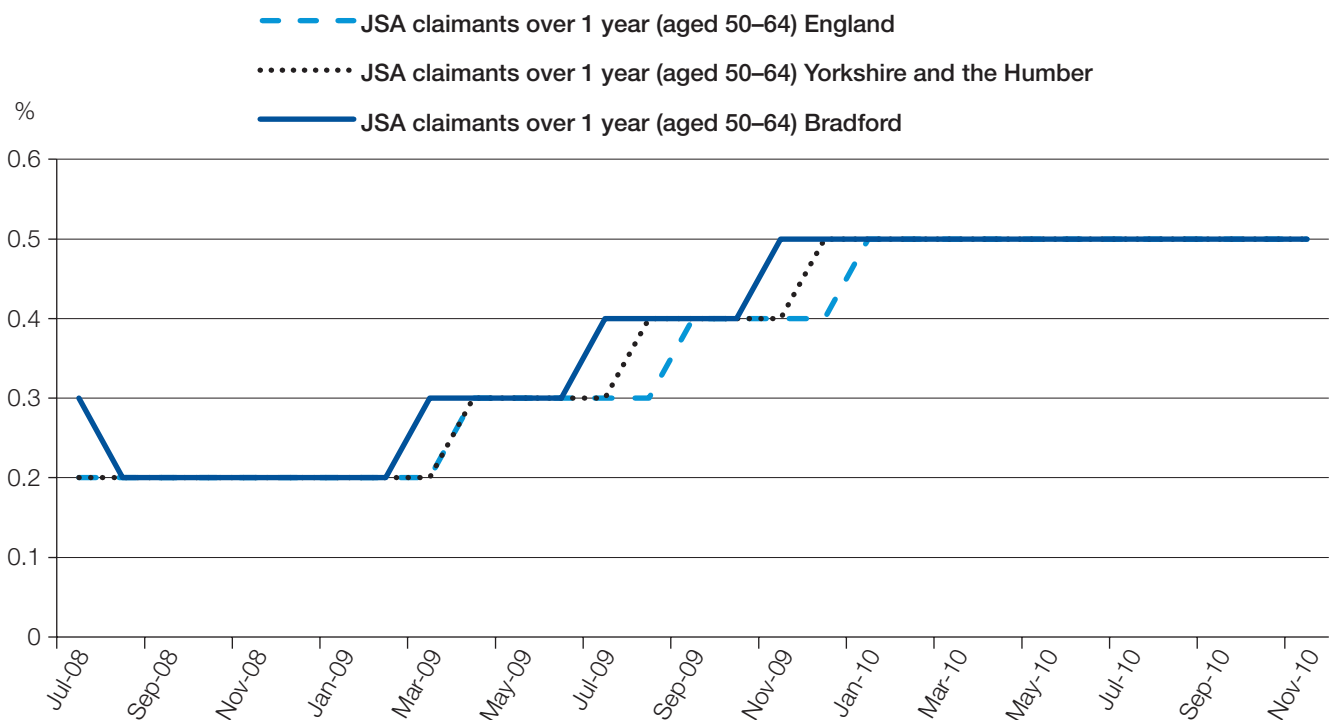
Source: ONS claimant count
Notes: Age and duration with proportions.

Figure 12: All people aged 50–64 claiming JSA for over six months and up to one year in Bradford, Yorkshire and the Humber and England between July 2008 and November 2010



Source: ONS claimant count
Notes: Age and duration with proportions.

Figure 13: All people aged 50–64 claiming JSA for over one year in Bradford, Yorkshire and the Humber and England between July 2008 and November 2010



Source: ONS claimant count
Notes: Age and duration with proportions.

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